

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

01337

40

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Baltimore  
 City or town..... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Charles Albright

## 3. (b) Social Security Number

4. Sex.....

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

April 19 - 1869

6. (c) If alive, give age..... years

8. AGE:

Tears

Months

Days

If less than one day

78 76 9

hrs.

min.

9. Birthplace.....

Md.  
(Town, county, and state)

10. Usual occupation.....

Carpenter

11. Industry or business.....

Chas Albright

12. Name.....

Md.

13. Birthplace.....

Unknown

14. Maiden name.....

15. Birthplace.....

16. Informant.....

John Albright

Address.....

Baltimore Md.

17. ....

(Burial, cremation, or removal, which)

Date thereof.....

Feb. 6 - 48  
(month) (day) (year)

Cemetery or crematory.....

S. St. Paul Lutheran Church

Location.....

Sweet Air Md.

18. Funeral director.....

Address.....

Clarence E. Arthur  
Fork Md.

19. ....

Feb. 5 - 48  
(Date rec'd by registrar)C. E. Arthur

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 4, 1948 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

February 17, 1947 to 2/4 19 48and that I last saw him alive on February 3 19 48

Immediate cause of death.....

congestive heart failure  
coronary atherosclerotic heart disease

DURATION

2 wks

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Address..... Clifford F. Hudson, M.D.  
Fork Md. Date signed 2/5/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 01326

## 1. PLACE OF DEATH:

County BaltoCity or town Middle River  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Route 16 Box 126

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State 2nd County BaltoCity or town Route 16 Box 126  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James Alexander

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Annie M. Grover7. Birth date of deceased (mo., day, yr.) August 3 - 1862 6. (c) If alive, give age 76 years8. AGE: Years 85 Months 5 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Ireland  
(Town, county, and state)10. Usual occupation Retired11. Industry or business Stand Oil Co.12. Name Uncle13. Birthplace Ireland14. Maiden name Uncle15. Birthplace Ireland16. Informant Madame Alexander (son)Address Route 16 Box 12617. Burial Date thereof 2-5-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. John's Lutheran Ch.Location Golden Key Rd.18. Funeral director John G. ConnollyAddress 418 Eastern Ave.2-3-48 John G. Connolly  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 1948 at 8 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31 1948 to Feb 1 1948and that I last saw him alive on Feb 1 1948Immediate cause of death CoronarythrombosisDue to arteriosclerotic cardiacvascular disease

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ injured at work? \_\_\_\_\_

23. SIGNATURE Geo. M. CunninghamAddress Balto 6 MdDate signed 2-1-48

M. D. or other \_\_\_\_\_

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01338

13/a

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Rosemont  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? About 22 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Baltimore  
 City or town Rosemont  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3025 Alabama Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3.(a) FULL NAME

CONCETTA I. AUGUSTINO

## 3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Anthony Augustino

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1877.

8. AGE: Years 70 Months 8 Days 28 If less than one day  
 hrs. min.

9. Birthplace Italy  
(Town, county, and state)10. Usual occupation House-Work  
At Home

11. Industry or business

12. Name Raymond Dolce13. Birthplace Italy14. Maiden name Rosina ?15. Birthplace Italy16. Informant Raymond Carnucci ( Son )  
Address 3411 Hudson St., Balto., Md.17. Burial Date thereof 2-17-48.  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy Redeemer Cemetery.Location 4430 Belair Rd.18. Funeral director Charles S. ZeilerAddress 901 S. Conkling St. Balto., Md.19. 2-16-48 (Date rec'd by registrar) 19 48 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1948 at 3:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1947 to Feb. 14 1948and that I last saw her alive on 2-14-48 1948Immediate cause of death Terminal bronchiopneumonia. DURATION 4-5 yrs.Due to Cardio hypertrophychronic bronchitisDue to general arteriosclerosisOther conditions hypertension, arteriosclerosisand ischem.  
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. Dolce M.D. M. D. or otherAddress 642 Wash. St. Date signed 2-16-48.



50 Rangle

643 Wash. Blvd.

10-10-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

01339

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: Baltimore  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 14 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
Maryland County.....  
Baltimore  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 111 Bloomsbury Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME Lizzie Baldurn

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife John L. Baldwin  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) 12-20-1865  
 8. AGE: Years Months Days If less than one day  
82 1 17..... hrs. .... min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business  
 12. Name Querry Jones  
 13. Birthplace England  
 14. Maiden name ✓  
 15. Birthplace

16. Informant Mrs. John J. Scannell  
 Address 111 Bloomsbury Ave  
 17. Burial Date thereof 2-10-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory London Park  
 Location Baltimore  
 18. Funeral director Caw L. Marnett  
 Address Batonville - Md.  
 19. 2-10 1948 VE Harry  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

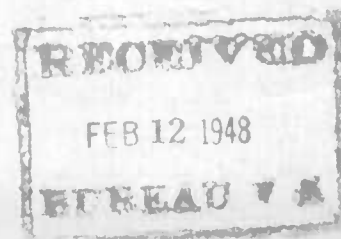
20. DATE OF DEATH Feb 7 1948 at 4:30 AM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 46 to 2/7 1948  
 and that I last saw him alive on 2/7 1948  
 Immediate cause of death..... DURATION  
Chronic interstitial  
nephritis with hypertension  
and Cardiovascular defect 4 days.  
 Due to.....  
 Due to.....  
 Other conditions Arteriosclerosis ?  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Daniel P. Kallin M. D. of other  
33 Hopkins Ave Date signed 2/9/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 73 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? 73 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto.City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 8026 Philadelphia Rd.

(If rural, give LOCATION)

2(a) If veteran, name war WW II

## 3. (a) FULL NAME

JAMES C. BAMFORD

## 3. (b) Social Security Number

213-07-1276

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Anna M. Bamford6. (c) If alive, give age 26 years7. Birth date of deceased (mo., day, yr.) 5-1-17

8. AGE: Years Months Days If less than one day

30925

hrs.

min.

9. Birthplace Follenshee, W. Va.

(Town, county, and state)

10. Usual occupation Filling Station

11. Industry or business

12. Name Thomas Bamford13. Birthplace England14. Maiden name Ann Marie Thompson15. Birthplace Ohio16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof 3/1/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Md.Howard N. Blight Jr.

Howard Blight Funeral Home

Address 4914 Belair Rd., Balto., Md.

18. Funeral director

19. 3/1 19 48 H. W. Hedrick Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 19 48 at 7:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 19 47 to February 26 19 48and that I last saw him alive on February 26 19 48Immediate cause of death (1) Adeno-carcinomaof sigmoid with liver metastases Since(2) Obstruction of transverse Sept. 19 46xxx colon due to carcinomatosis

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. ManaghH.C. MANAGH, M.D. Chief ProfessionalAddress V.A. Ft. Howard, Md. Date signed 2-27-48

## CERTIFICATE OF DEATH

Registered No. 01341

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2904 OAKCREST AVE

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County Baltimore

(c) City or town BALTIMORE  
(If outside city or town limits, write RURAL and give town)(d) Street No. 2904 OAKCREST AVE  
(If rural give location)(e) Citizen of foreign country? (Yes or No)  
If yes, name country.

## 3 (a) FULL NAME

ROSE ELIZABETH BIGGS

3 (b) If veteran, name was

No

3 (c) Social Security Account

No

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

MARRIED

6 (b) Name of husband or wife FREDERICK L. BIGGS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

MARCH 27, 1919

8. AGE: Years

58

Months

11

Days

2

If less than one day

hr.

min.

9. Birthplace

WEST NEWTON, PA.

(Town, county, and state)

10. Usual Occupation

HOUSEWIFE

11. Industry or business

12. Name

JOSEPH VOGEL

13. Birthplace

PA.

14. Maiden Name

UNKNOWN

15. Birthplace

MRS. DOROTHY G. MUSE -

DAUGHTER

16 (a) Informant

2904 OAKCREST AVE

(b) Address

17 (a)

BURIAL

(b) Date thereof

3/3/48

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

PARKWOOD

Location

BALTO. MD.

18 (a) Funeral director

Wm. J. TICKNER &amp; SONS

(b) Address

BALTIMORE MD.

19 (a)

3-6-48

(b)

F. W. Hedrich

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

2/29

1948, at 3:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from February 11, 1948, to Feb. 29, 1948, and that I last saw him alive on Feb. 29, 1948.

Immediate cause of death

Carcinoma of right breast

Due to

Due to

Other Conditions

General metastasis  
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Benjamin Kader

M. D.

Address 2306 Eustaw Pl Date signed 3-1-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

01342

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Towson, West Road  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 9 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Ind County Baltimore  
 City or town Towson  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Joseph Linton Black

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

malewhitewidowed6.(b) Name of husband or wife Eliza Graham7. Birth date of deceased (mo., day, yr.) July 19, 18598. AGE: Years Months Days It less than one day  
88 7 3 hrs. min.9. Birthplace Pa

(Town, county, and state)

10. Usual occupation Retired Carpenter

11. Industry or business

12. Name William Black13. Birthplace Ireland14. Maiden name Unknown15. Birthplace Ireland16. Informant J. Graham BlackAddress West Rd. Towson, Ind17. Burial Date thereof Feb. 24 - 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lorraine ParkLocation Winton Hill Rd.19. Funeral director Howard S. MankinAddress White House, Ind20. Feb. 23 19 48

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 19 48 at 11:43 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-4 19 47 to 2-21 19 48and that I last saw him alive on 2-19 19 48

Immediate cause of death

Heart Failure

DURATION

2-24-48Due to Valvular Heart DiseaseDue to unk

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations noneDate of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

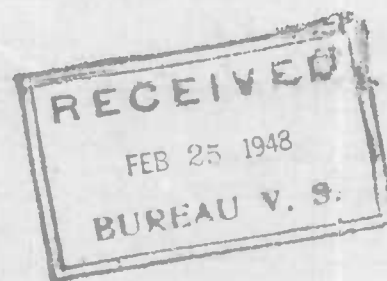
Means of injury Injured at work?

23. SIGNATURE Bennett A. Stoen

M. D. or other

Address LuthervilleDate signed 2/23/48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01343 31

### 1. PLACE OF DEATH:

County.....**Baltimore**  
City or town.....**Woodlawn**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....**49 YRS. 9 MOS. 19 DAYS**  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?.....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State.....**Md.** County.....**Baltimore**  
City or town.....**Woodlawn**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....**5810 Windsor Mill Rd.,**  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3.(a) FULL NAME

**Edith A. Bonsall**

### 3.(b) Social Security Number

**none**

4. Sex.....**Female**  
5. Color or race.....**White**  
6.(a) Single, married, widowed, or divorced.....**Married**

6.(b) Name of husband or ~~XX~~ **Joseph C. Bonsall**

7. Birth date of deceased (mo., day, yr.).....**April 26, 1898**  
6.(c) If alive, give age..... years

8. AGE: Years.....**49** Months.....**9** Days.....**19**  
It less than one day..... hrs. .... min.

9. Birthplace.....**Baltimore Co., Md.**  
(Town, county, and state)

10. Usual occupation.....**House-wife**

11. Industry or business.....**Daniel E. Smith**

12. Name.....**Daniel E. Smith**

13. Birthplace.....**Md.**

14. Maiden name.....**Mary E. Rittler**

15. Birthplace.....**Md.**

16. Informant.....**Mr. Joseph C. Bonsall**  
Address.....**5810 Windsor Mill Road**

17.....**Burial** Date thereof.....**2-17-48**  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....**XX Lorraine Park**  
Location.....**Woodlawn, Md.**

18. Funeral director.....**J. Howard Strong**  
Address.....**3207 W. North Ave.,**

19.....**2/17** 19.....**48** **St. Hedrick**  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....**February 14, 1948** at.....**11.20** p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....**June 1** 19.....**47**, to.....**Feb. 14** 19.....**48**  
and that I last saw him ~~or~~ alive on.....**Feb. 14** 19.....**48**

Immediate cause of death.....**Cerebral hemorrhage and paralysis**  
DUE TO.....**myocarditis**  
DUE TO.....**arteriosclerosis**  
Other conditions.....  
(Include pregnancy within 3 months of death)

DURATION.....**3 days**  
**about 8 mo.**

Major findings of operations..... Date of op.....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
Means of injury..... Injured at work?.....  
Signature.....**Robert D. Leiby** M. D. or other  
Address.....**2220 Harrison Blvd** Date signed.....**Feb 16/48**

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01344

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville 28, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 yrs. 9 mos. 22 das.

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 6 yrs. 9 mos. 22 das.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 317 Park Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war. ☒

## 3. (a) FULL NAME

Katherine Brady

## 3. (b) Social Security Number

4. Sex <u>female</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>single</u>
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6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 20, 18718. AGE: Years 76 Months 6 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Seamstress11. Industry or business Dressmaker12. Name John Brady13. Birthplace ?14. Maiden name Isabella Hughes15. Birthplace ?16. Informant Hospital RecordsAddress Catonsville 28, Maryland17. 2/28/48 Date thereof 2/28/48  
(Burial, cremation, or other disposal) (month, day, year)Cemetery or crematory Bethel CathedralLocation Balto. City18. Funeral director C. Vernon GammannAddress 4611 Park Heights Ave.19. Feb. 26 1948 V.E. Harry  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 19 48 at 4:45a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 3, 1941 to February 25, 1948and that I last saw him alive on February 25, 19 48

Immediate cause of death

Cerebral hemorrhage, Massive,  
left parietal.

## DURATION

1 weekDue to Cerebral Arteriosclerosis.Generalized arteriosclerosisyearsDue to Valvular heart disease.years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk, M.D.

M. D. or other

Address Catonsville 28, Md. Date signed 2/25/48

RECEIVED

MAR 2 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01345 44  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 37 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Md.How long in hospital or institution? 37 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 225 N. Gilmore St.  
(If rural, give LOCATION)2.(a) If veteran, name war WW-I

## 3. (a) FULL NAME

WEBB BRAXTON

## 3. (b) Social Security Number

705-12-37074. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Elizabeth Braxton6.(c) If alive, give age 52 years7. Birth date of deceased (mo., day, yr.) November 10, 18938. AGE: Years 54 Months 3 Days 18 If less than one day  
.....hrs. ....min.9. Birthplace Essex Co., Virginia  
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Wake Braxton13. Birthplace Virginia14. Maiden name Sarah ?15. Birthplace Virginia16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof 3-2-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation 5501 Frederick Rd. Balto. Md.18. Funeral director Charles G. CooperAddress 512 N. Carrollton Ave. Balto. Md.19. 3/2 KP R. D. Hedrick  
(Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 19 48 at 8:25A M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from  
January 22 19 48 to February 28 19 48and that I last saw him alive on February 28 19 48Immediate cause of death RETROPERITONEAL SARCOMA;  
EXTENSION TO HEAD OF PANCREAS;  
WIDESPREAD METASTASES DURATION Unknown

Due to

Due to Unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. E. Shaw, M.D. M. D. or otherAddress VAH Ft. Howard, Md. Date signed 2-28-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 9 Frederick Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.

## 3. (a) FULL NAME

John Brown

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single  
 6.(b) Name of husband or wife  
 6.(c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) June 24, 1890  
 8. AGE: Years 57 Months 7 Days 25 If less than one day  
 hrs. min.

9. Birthplace Pennsylvania  
 (Town, county, and state)  
 10. Usual occupation Machine work  
 11. Industry or business Mill  
 12. Name Luckey Garzstka  
 13. Birthplace Germany  
 14. Maiden name Sophie Brown  
 15. Birthplace Germany

16. Informant Hospital records  
 Address Catonsville-28, Maryland  
 17. Burial Date thereof 3-10-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Spring Grove State Hospital  
 Location Catonsville 28, Md.  
 18. Funeral director Spring Grove Hospital  
 Address Catonsville 28, Md.

19. March 10, 1948 V E. Harry  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 19 48 at 12:35p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 19 22, to February 18 19 48  
 and that I last saw him alive on February 18 19 48

Immediate cause of death  
Lobar pneumonia, right upper and lower lobes  
 Due to Cachexia, secondary to adenocarcinoma of the liver metastatic from adenocarcinoma of the rectum.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk, M.D. M. D. or otherAddress Catonsville-28, Md. Date signed 2-18-48



RECEIVED

MAR 13 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01347

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

### 1. PLACE OF DEATH:

County Balto  
City or town Stonleigh  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Armadillo Nursing Home  
812 Register Ave  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County a. a.  
City or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Mary FORD Brown

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced  
Widowed  
6. (b) Name of husband or wife David E. Brown  
7. Birth date of deceased (mo., day, yr.) Nov 10<sup>th</sup> 1865  
6. (c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 82 Months 3 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Palatine Ill.  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business At Home  
12. Name Ford  
13. Birthplace N. Y.  
14. Maiden name Mary  
15. Birthplace N. Y.

16. Informant Ford R. Brown  
Address 243 King Geo. St. Annapolis, Md.  
17. Cremation Date thereof 2/20/48  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory Green Mount  
Location Balto. Md.  
18. Funeral director William Cook Inc.  
Address 1217 St. Paul St  
18 48  
19. (Date rec'd by registrar) \_\_\_\_\_ Registrar \_\_\_\_\_

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 18, 1948 at 3<sup>20</sup> A. M.  
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 10, 1947 to Feb 18, 1948  
and that I last saw him alive on Feb 16, 1948  
Immediate cause of death Heart disease, chronic  
myocarditis, decompensation and  
some fibrillation  
Due to Hypertension  
Due to Arteriosclerosis  
Other conditions Pylor. nephritis, chronic  
Central hemorrhage  
(Include pregnancy within 3 months of death)  
DURATION  
1 yr +  
unk  
unk  
4 mos  
1 yr +

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: \_\_\_\_\_  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. Signature Rollin F. Hudson MD.  
M. D. or other \_\_\_\_\_  
Address Towson Md Date signed 2/18/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incomplete or incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01348

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County... Balto.City or town... Halethorpe  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... BaltoCity or town... Halethorpe  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2056 Northeast Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (a) FULL NAME

Mollie Brown

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

Humphrey

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.)

July 10 - 1892

8. AGE:

Years

Months

Days

If less than one day

5584

...hrs.

...min.

9. Birthplace

Virginia  
(Town, county, and state)

10. Usual occupation

domestic

11. Industry or business

MOTHER FATHER

12. Name

Arch Williams

13. Birthplace

Va

14. Maiden name

Charlotte P

15. Birthplace

Va

16. Informant

Miriam Ranson

Address

2056 Northeast Ave

17.

(Burial, cremation, or removal. Which?)

Date thereof

2-18-48  
(month) (day) (year)

Cemetery or crematory

Arden

Location

Balto. Co

18. Funeral director

Samuel W. Sullivan, Jr

Address

1011 N. Calverton Ave. Balto

19.

2/17  
(Date rec'd by registrar)

19.

48A. W. Hedrick  
DM Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Feb 14 19 48 at 3 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 31

19

48

to

Feb 14

19

48

and that I last saw him alive on

Feb 14

19

48

Immediate cause of death

Cerebral Hemorrhage

DURATION

3 days

Due to

Hypertension

Due to

Other conditions

Acute Congestive Failure  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. Garland Chisell Jr.

M. D. or other

Address

902 W. Franklin

Date signed

2-16-48

M

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore  
CERTIFICATE OF DEATH

50

01342  
38

Reg. Dist. No. ....

1. PLACE OF DEATH:  
County Baltimore  
City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 11 years  
Hospital, institution, or street address where death occurred:  
113 Ware Avenue  
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 113 Ware Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war —

3. (a) FULL NAME  
Sarah (Sally) Elizabeth Bruns

3. (b) Social Security Number  
—

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
6. (b) Name of husband or wife Bernard P. Bruns  
deceased —  
6. (c) If alive, give age — years  
7. Birth date of deceased (mo., day, yr.) March 17, 1866  
8. AGE: Years 81 Months 10 Days 24 It less than one day — hrs. — min.

9. Birthplace Towson, Md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

12. Name John T. Smith

13. Birthplace Ireland

14. Maiden name Bridge H. Scalley

15. Birthplace Ireland

16. Informant Miss Margaret H. Smith

Address 113 Ware Ave., Towson, Md.

17. Burial Date thereof Feb. 14, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Mt. Maria Cemetery  
Towson, Md.

18. Funeral director John Burns' Sons  
Towson, Md.

Address —  
19. Feb. 14 19 48  
(Date rec'd by Registrar) Registrar —

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 19 48 at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 38 to Feb 11 19 48

and that I last saw him alive on Feb 11 19 48

Immediate cause of death Carcinoma, scirrhous  
left breast, general metastasis

DURATION  
18 mo.

Due to —

Due to —

Other conditions Cachexia

3 mo.

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide — Date of —

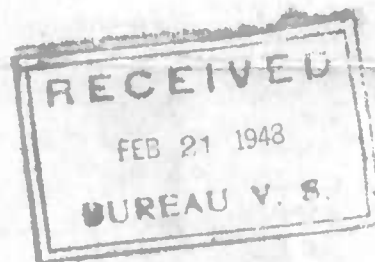
Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Rollin C. Hudson M.D.  
M. D. or other —

Address Towson, Md. Date signed 2/11/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01350 43

## 1. PLACE OF DEATH:

County Baltimore  
City or town Rosedale  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town Rosedale  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 7941 Oakdale Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Joseph Frank Bures

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Mary Bures7. Birth date of deceased (mo., day, yr.) March 6, 1860 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 88 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Baltimore  
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

12. Name John Bures13. Birthplace Baltimore14. Maiden name Not Known15. Birthplace Baltimore16. Informant John BuresAddress 2938 E. Monument17. Burial Date thereof 2-10-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Holy RedeemerLocation Baltimore Md18. Funeral director Frank BrachmanAddress 900 N. C. Chester St19. 2/9/48 19 C. W. Seduck  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 19 48 at 12:40 P.M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 48 to Feb 6 19 48and that I last saw him/her on Feb 6 19 48Immediate cause of death Coronary  
thrombosis

## DURATION

Due to Arteriosclerotic Cardiac  
vascular disease 2 yrs

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. Brumgardner M. D. or otherAddress Balto 6 Md Date signed 2-6-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate sex, age, and cause of death clearly and legibly. It is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01351

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 256 days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp. Fort Howard, Md.  
 How long in hospital or institution? 256 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3568 Horton Avenue  
 (If rural, give LOCATION)  
WW I  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

JOSEPH F. BUTKA

## 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Ida M. Butka  
 6. (c) If alive, give age 58 years  
 7. Birth date of deceased (mo., day, yr.) August 30, 1890  
 8. AGE: Years 57 Months 5 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation Unemployed  
 11. Industry or business

FATHER 12. Name Joseph Butka  
 13. Birthplace Bohemia  
 MOTHER 14. Maiden name Barbara Vanacek  
 15. Birthplace Bohemia

16. Informant Clinical Records, Vets. Adm. Hosp.  
 Address Fort Howard, Maryland

17. Burial Date thereof 2-11-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Holy Cross  
 Location Anne Arundel Co., Md.

18. Funeral director Jerome Cvach  
 Address 900 North Chester St., Balto., Md.

19. 2/9/48 19 \_\_\_\_\_  
 (Date rec'd by registrar) Registrar A. D. Hedrick

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 19 48 at 6:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 19 47 to February 7 19 48  
 and that I last saw him alive on February 7 19 48

Immediate cause of death  
Cardiac Dilatation & Hypertrophy

DURATION  
Unknown

Due to Rheumatic mitral stenosis & Insufficiency

Unknown

Other conditions Hemohydrothorax, right

Unknown

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Bernard F. Fetter  
BERNARD F. FETTER, M.D. M. D. or other  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

01352

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville 28 12 Arthur Ave.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 yrs  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 12 Arthur Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Roy Russell Clark

## 3. (b) Social Security Number

213-09-6351

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

W

## 6. (b) Name of husband or wife

Stella VirginiaClark

## 6. (c) If alive, give age

Deceased

## 7. Birth date of deceased (mo., day, yr.)

Apr. 4, 1888

## 8. AGE:

59

Years

10

Months

16

Days

## If less than one day

hrs.

min.

## 9. Birthplace

Laurel, Md.  
(Town, county, and state)

## 10. Usual occupation

Electrician

## 11. Industry or business

FATHER

## 12. Name

Henry Clark

## 13. Birthplace

Laurel, Md.

MOTHER

## 14. Maiden name

Emma Specht

## 15. Birthplace

Frederick Md.

## 16. Informant

Mrs. George Meldron

## Address

12 Arthur Ave. Catonsville

## 17. (Burial, cremation, or removal, which?)

Burial

## Date thereof

Feb. 24, 1948  
(month) (day) (year)

## Cemetery or crematory

St. Johns Cem.

## Location

Elkhatt City, Md.

## 18. Funeral director

Easton Sons

## Address

608 Frederick Ave. Catonsville, Md.

## 19.

Feb. 24, 1948

(Date rec'd by registrar)

V. E. Harris

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

20 Feb

19

48, at 10:55 P. M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

14 Feb

19

48, to 20 Feb

19

48

## and that I last saw him alive on

20 Feb

19

48

## Immediate cause of death

Pneumonia

## DURATION

12 hrs.

## Due to

## Due to

## Other conditions

Chronic Congestive Heart Disease

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Carl W. Ryan M.D.

M. D. or other

Address

142 W. Barton Ave. Catonsville, Md.

Date signed

20 Feb 48

RECEIVED

FEB 26 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*Evidence for change of age shown on*  
 FILM NO. G 114 FEB 25 1948

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

131a

01353

Reg. Dist. No. 38

1. PLACE OF DEATH:  
 County Baltimore  
 City or town Towson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since February 6, 1948  
 Hospital, institution, or street address where death occurred:  
SHEPPARD AND ENOCH PRATT HOSPITAL  
 How long in hospital or institution? Since February 6, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2814 St. Paul Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

### 3. (a) FULL NAME

DAVID GRAVES CLEMENT *SR*

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Ella Mae Clement

7. Birth date of deceased (mo., day, yr.) February 15, 1864 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 83 ~~84~~ Months 11 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Harford County, Md.  
 (Town, county, and state)

10. Usual occupation Lumber business

11. Industry or business

12. Name Thomas Clement  
 13. Birthplace Harford County, Md.

14. Maiden name McCoy  
 15. Birthplace Harford County, Md.

### 16. Informant HOSPITAL RECORDS

Address Funeral  
 Date thereof 2/16/48  
 (month) (day) (year)  
 Cemetery or cremation SOUTHERN METHODIST  
 Location 443 E. N. Ave.  
Belton, Md.

18. Funeral director William J. Coul

Address 1219 E. Coul St.  
2/16  
 (Date rec'd by registrar) 19. Dr. A. W. Hedrick  
 Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 13, 1948 at 2:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 6, 1948 to February 13, 1948

and that I last saw him alive on February 13, 1948

Immediate cause of death Cerebral vascular accident DURATION 2 weeks

Due to Cerebral arteriosclerosis & probable nephrosclerosis Unk.

Due to Uremia 8 days

Other conditions Psychosis with cardiorenal disease.  
 (Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Autopsy not done confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically (JRF)

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry M. Mirdock, M.D. M. D. or other

Address Towson 4, Md. Date signed 2/13/48

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01354

Reg. Dist. No. 34

1. PLACE OF DEATH  
County Baltimore  
City or town Crofton  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 78 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Crofton  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Upsona Rd. R. 8. #1  
(If rural, give LOCATION)  
2.(g) If veteran, name war

3. (a) FULL NAME William Melancthon Cooper 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Lena Belle Cooper  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) Sept. 21-1869

8. AGE: Years 78 Month 4 Days 27 hrs. min.

9. Birthplace Crofton, Balto. Co. Md.  
(Town, county, and state)

10. Usual occupation Ret. Tinner

11. Industry or business Garmentmaker

12. Name William Cooper  
13. Birthplace Crofton Balto. Co. Md.

14. Maiden name Amelia Anne  
15. Birthplace Crofton, Balto. Co. Md.

16. Informant Wm. Lena Belle Cooper  
Address Upsona Rd. R. 8. #1, Crofton

17. (Burial, cremation, or removal, Which?) Burial Date thereof 2-21-48  
(month) (day) (year)

Cemetery or crematory Crofton Lutheran

Location Balto Co Md

18. Funeral director Edison Tipton

Address Hampstead Md

19. Feb 18 1948 C. E. Foster M.D. Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1948 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 28 1948 to Feb 18 1948  
and that I last saw him alive on Feb 18 1948

Immediate cause of death Bronchogenic Carcinoma of Lung  
DURATION unknown

Due to  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph E. Bush M.D. M. D. or other  
Address Hampstead Md Date signed 2-18-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Anderson  
3003 Shannon Drive

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01355

Reg. Dist. No. 43

### 1. PLACE OF DEATH:

County Overlea  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7417 Brookwood Road

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Overlea

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7417 Brookwood Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

BEULAH CLARA DE ARMENT

### 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Guy Horace De Arment

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1880 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 67 Months 5 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Marian Station, Md.  
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name John Johnson

13. Birthplace Md.

14. Maiden name ?

15. Birthplace ?

16. Informant Mrs. Eric Gadsby

Address 7417 Brookwood Road, #6

17. Burial Burial Date thereof 2-14-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lorraine Park

Location Baltimore, Md.

18. Funeral director Leonard J. Ruck

Address 5305 Harford Road, #14

19. 2-11-48 Registrar John Edick

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 11th, 1948 at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 1 1948 to Feb 11 1948  
and that I last saw her alive on Feb 11 1948

Immediate cause of death Cerebral Hemorrhage DURATION

Due to arteriosclerosis

Due to Hypertension

Other conditions Enlarged & Dilated

Leaky Heart. (Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Walter Anderson M. D. or other

Address 3001 Shannon Drive Date signed 2/11/48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01356

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH

County BaltimoreCity or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2-6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

George William Dell

## 3. (b) Social Security Number

218-10-34474. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Fannie T. Dell7. Birth date of deceased (mo., day, yr.) May 9-1865 6. (c) If alive, give age ..... years8. AGE: Years 82 Months 9 Days 2 If less than one day ..... hrs. .... min.9. Birthplace Carroll Co. Maryland  
(Town, county, and state)10. Usual occupation Machinist11. Industry or business Retired 9 Months12. Name George W. Dell13. Birthplace Maryland14. Maiden name Louise Martin15. Birthplace Maryland16. Informant M. Eugene DellAddress 6 Seven Mile Lane17. Burial Date thereof Feb. 14-1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium Druid RidgeLocation Pikesville, Maryland18. Funeral director Burpee Funeral HomeAddress 3631 Falls Road19. 2/13/48 Registrar E. W. Hedrick

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6 Seven Mile Lane  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

## MEDICAL CERTIFICATION

2D. DATE OF DEATH February 11-1948 at 2:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1942 to Feb. 11, 1948and that I last saw him alive on Feb. 11, 1948

Immediate cause of death

Cardiovascular DiseaseDue to Arteriosclerosis

Due to.....

Other conditions CardiomegalyApparently care of liver(Include pregnancy within months of death) 4/6/48

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. E. MartinAddress Randallstown, Md.Date signed 2/12/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-13M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr. J. M. E. Martin  
Roslyn 1374 J1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01357

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County BALTIMORE  
 City or town MERCYVILLE  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 YRS  
 Hospital, institution, or street address where death occurred:  
COVENS 12  
 How long in hospital or institution? 5 YRS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MARYLAND County BALTIMORE  
 City or town RURAL  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. COVES 12, MARYLAND  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

ARABELLA DENVER

## 3. (b) Social Security Number

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED  
 6.(b) Name of husband or wife ANDREW  
 7. Birth date of deceased (mo., day, yr.) JULY 23, 1958  
 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 94 Months 7 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace PA.  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name CHARLES KOEHLER  
 13. Birthplace PA.  
 14. Maiden name UNKNOWN (SNEAD)  
 15. Birthplace UNKNOWN

16. Informant Sister Mary Clement  
 Address Mercy Hospital Maets. Md

17. BURIAL Date thereof Mar 2/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory ST MARY'S CEMETERY  
 Location ANNAPOLIS, MARYLAND

18. Funeral director BEN E. HOPPING & SON  
 Address 170-172 WEST ST. ANNAPOLIS MD.

19. March 1, 1948  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27 1948, at 7:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
1-15 1947, to 2-27 1948  
 and that I last saw him alive on 2-27 1948

Immediate cause of death Arteriosclerotic Cardiovascular Disease  
 Due to Diabetes Mellitus  
 Due to Cancer of Uterus  
 Other conditions Uterus  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE P.O. Flynn M. D. physician

Address "P. O. Flynn" Date signed 2-28-48

RECEIVED

MAR 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01358

Reg. Dist. No. 40

<b>1. PLACE OF DEATH:</b> County..... <u>Kingsville</u> City or town..... <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>Sunshine Avenue</u> How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Kingsville</u> City or town..... <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>Sunshine Avenue</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
<b>3. (a) FULL NAME</b> <u>Magdalena D. Devers</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>female</u>		<b>5. Color or race</b> <u>white</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>widowed</u>		<b>MEDICAL CERTIFICATION</b>	
<b>6. (b) Name of husband or wife</b> <u>Arthur L. Devers</u>				<b>20. DATE OF DEATH</b> <u>February 16</u> 19 <u>48</u> at <u>1</u> P. M.			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>July 3, 1876</u>				<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>Nov. 3, 1947</u> to <u>Feb. 16, 1948</u> and that I last saw her alive on <u>Feb. 15, 1948</u> Immediate cause of death..... <u>Coronary Thrombosis</u> DURATION <u>3da.</u> <u>General Atherosclerosis</u> <u>Hypertension, Cardis -</u> <u>Takayasu Disease</u> Other conditions..... (Include pregnancy within 3 months of death)			
<b>8. AGE:</b> Years <u>71</u> Months <u>7</u> Days <u>13</u> If less than one day..... hrs. .... min.		<b>9. Birthplace</b> <u>Baltimore, Maryland</u> (Town, county, and state)		<b>10. Usual occupation</b> <u>at home</u>		<b>Due to</b> .....	
<b>11. Industry or business</b> <u>Phillip Gross</u>		<b>12. Name</b> <u>Barbara ?</u>		<b>13. Birthplace</b> <u>Germany</u>		<b>Due to</b> .....	
<b>14. Maiden name</b> <u>Barbara ?</u>		<b>15. Birthplace</b> <u>?</u>		<b>Major findings of operations</b> Date of op. ....		<b>Autopsy results</b> PHYSICIAN: Please underline the cause to which death should be charged statistically.	
<b>16. Informant</b> <u>Mrs. Joseph K. Klein</u> Address <u>Sunshine Avenue, Kingsville</u>				<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of ..... Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?			
<b>17. Burial</b> (Burial, cremation, or removal, Which?) Date thereof <u>2-19-48</u> (month) (day) (year) Cemetery or crematory..... <u>Parkwood Cem.</u> Location..... <u>Baltimore, Md.</u> <b>18. Funeral director</b> <u>Leonard J. Ruck</u> Address <u>5305 Harford Road, 14</u>				<b>23. SIGNATURE</b> <u>Clifford J. Hudson, M.D.</u> M. D. or other Address <u>Fork Md.</u> Date signed <u>2/19/48</u>			
<b>19.</b> <u>2/19/48</u> (Date rec'd by registrar) Registrar				<b>20.</b> <u>2/19/48</u> (Date rec'd by registrar) Registrar			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

1316  
01359

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County.....Baltimore  
 City or town.....Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 176 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Maryland  
 How long in hospital or institution? 176 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State.....Maryland County.....  
 City or town.....Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 214 Oakdale Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW-2

## 3. (a) FULL NAME

KENNETH DEWART

## 3. (b) Social Security Number

218-05-6968

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Anna L. Dewart  
 7. Birth date of deceased (mo., day, yr.) 4-3-12 6.(c) If alive, give age 40 years  
 8. AGE: Years 35 Months 10 Days 22 If less than one day .....hrs. ....min.

9. Birthplace.....Boston, Mass.  
 (Town, county, and state)  
 10. Usual occupation.....Unemployed  
 11. Industry or business.....  
 12. Name Murray W. Dewart  
 13. Birthplace St. Paul, Minn.  
 14. Maiden name Submit Clark  
 15. Birthplace Manchester, N.H.

16. Informant.....Clinical Records, Vets. Adm. Hosp.  
 Address Ft. Howard, Maryland

17. Burial Date thereof 2/27/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory.....Baltimore National Cemetery  
Baltimore, Maryland  
 Location.....Howard N. Blight Jr.  
 18. Funeral director.....Howard Blight, Jr.  
 Address 4914 Belair Rd., Balto., Md.

19. Feb 26 19 48 A.W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 19 48 at 8:02 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
September 2, 19 47, to February 25, 1948  
 and that I last saw him alive on February 25, 19 48

Immediate cause of death..... DURATION  
Coronary Thrombosis with infarction Unknown

~~Other cond:~~ History of hyper-  
 tension -- 2 Yrs; Cardiac dilatation  
~~and~~ Hypertrophy -- 2 Yrs;  
 Arteriosclerosis, generalized Unknown  
 Nephritis, chronic, duration, Unknown  
~~and~~ Pulmonary infarct, rt. Unknown  
 Veiled patent foramen ovale  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results Substantiated above.  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE H.C. MANAUGH  
H.C. MANAUGH, M.D. Chief Professional  
 Address V.A.H. Ft. Howard, Md. Date signed 2-25-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01360

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Colonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hood Convent Home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Colonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 615 Plymouth Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Ellen "Lollie" V. Dobb

## 3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 4 - 1866

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 81 Months 8 Days 78 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Baltimore, Md  
(Town, county, and state)10. Usual occupation None

## 11. Industry or business

12. Name John Dobb13. Birthplace MARYLAND14. Maiden name Sarah E. Dobb15. Birthplace MARYLAND16. Informant Theo. HentzAddress 615 Plymouth Rd.17. Burial Date thereof Feb 4 - 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Green MountLocation Balto. Md18. Funeral director F.B. Wipbert & SonAddress 1300 Eutaw Pl. 1719. 2-6-48 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 - 48 at 7 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 - 48 to Feb 1 - 48 and that I last saw her alive on Feb 1 - 48Immediate cause of death Chr. MyocarditisDURATION 1 yr.Due to Generalized Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 5 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jessie Entwined M. D. or otherAddress Colonsville Date signed 2/3

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01361  
Reg. Dist. No. 42

### 1. PLACE OF DEATH:

County BALTIMORE  
City or town (RURAL) - Balto. 1222 ELM RIDGE AVE  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred: at home  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County BALTO  
City or town Arbutus  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1222 ELM RIDGE AVE  
(If rural, give LOCATION)  
2. (a) If veteran, name war No

### 3. (a) FULL NAME

LAWRENCE CONRAD DIETERICK

### 3. (b) Social Security Number

?

4. Sex MALE 5. Color or race White 6. (a) Single, married, widowed, or divorced WIDOWED  
6. (b) Name of husband or wife MRS. PRISCILLA J. DIETERICK  
NEE WISNER 6. (c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) AUG. 4, 1875  
8. AGE: Years 72 Months 6 Days 15 If less than one day

9. Birthplace MARYLAND  
(Town, county, and state)  
10. Usual occupation RETIRED  
11. Industry or business BALTO. TRANSIT CO  
12. Name JUSTUS DIETERICK  
13. Birthplace GERMANY  
14. Maiden name UNKNOWN  
15. Birthplace GERMANY

16. Informant MR. FRED. L. DIETERICK (SON)  
Address 1222 ELM RIDGE AVE  
17. BURIAL Date thereof 2/23/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory HOUDON PARK  
Location BALTIMORE, MD.

18. Funeral director WM. J. TICKNER & SONS INC.  
Address BALTIMORE, MD.

19. Feb 24 1948 Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19/48 at 9-15a M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
and that I last saw him alive on 19  
Immediate cause of death Coronary occlusion

DURATION  
Due to  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Leo J. Kieffer Sup Med  
M. D. or other  
Address 1010 Leaden Date signed 2-21-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 73

01362

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Overlea  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 29 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Baltimore  
 City or town..... Overlea  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 7001 Linden Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

KATIE A. DODSON

## 3. (b) Social Security Number

4. Sex..... female 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married  
 6.(b) Name of husband or wife..... Samuel C. Dodson  
 7. Birth date of deceased (mo., day, yr.)..... Dec. 31st, 1865  
 6.(c) If alive, give age..... years  
 8. AGE: Years..... 82 Months..... 1 Days..... 18 It less than one day..... hrs. .... min.

9. Birthplace..... Baltimore, Md.  
 (Town, county, and state)  
 10. Usual occupation..... at home  
 11. Industry or business.....

12. Name..... Andrew McCletchie  
 13. Birthplace..... Scotland  
 14. Maiden name..... Brasheers  
 15. Birthplace..... Baltimore, Md.

16. Informant..... Mr. S.C. Dodson  
 Address..... 7001 Linden Ave.  
 17. burial Date thereof..... 2/21/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Parkwood  
 Location..... Baltimore, Md.

18. Funeral director..... Lassahn Funeral Home  
 Address..... 7401 Belair Road

19. Feb. 19- 19. 48 Mrs. G. I. Ruffin  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 18th 19. 48 at 6:15 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 8, 1947, to Feb 18, 1948  
 and that I last saw her alive on Feb 17, 1948

Immediate cause of death..... Acute Heart Failure DURATION..... 2 hours

Due to..... Cardio-Vascular  
Hypertensive Disease 10 years  
 Due to..... Arteriosclerosis 10 years

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Michael J. Dorsch M.D.  
 M. D. or other

Address..... 1111 Overlea Ave Date signed..... 2/18/48

RECEIVED

FEB 24 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01363

Reg. Dist. No. 48

1. PLACE OF DEATH  
 County Baltimore  
 City or town Shimada (221 road)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Shimada (221 road)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 7731 Fairgreen Rd  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

3. (a) FULL NAME  
Delores Mae Dowdy

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1931 8. (c) If alive, give age years

8. AGE: Years 17 Months 0 Days 18 If less than one day  
 hrs. min.

9. Birthplace Huntingdon, W. Va.  
 (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Raymond E. Dowdy  
 13. Birthplace Cincinnati, Ohio

MOTHER 14. Maiden name Emily M. Bailey  
 15. Birthplace Eschdale, N. Y.

16. Informant Raymond E. Dowdy  
 Address 7731 Fairgreen Rd.

17. Burial Date thereof 2-24-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Int. Olivet  
 Location Baltimore

18. Funeral director George A. Forley  
 Address Fulton Ave + Fayette St.

19. 2/23/48 19 A. W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 19 48 at 12:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 46 to Feb. 12 19 48  
 and that I last saw him alive on Feb. 19 19 48

Immediate cause of death Atrophy of the brain DURATION 12 yrs

Due to fractured skull 12 yrs

Due to Convulsions 12 yrs

Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE David H. Andrews M.D. M. D. or other  
 Address 2 Kensington Shadeth 22 Date signed 2/23/48

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01364

Reg. Dist. No. 33

### 1. PLACE OF DEATH:

County..... Baltimore  
City or town..... Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 26 years  
Hospital, institution, or street address where death occurred:  
75 Main St Reisterstown Md  
How long in hospital or institution? -

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore  
City or town..... Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 75 Main St  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... No

### 3. (a) FULL NAME

Mary Elizabeth Tinkler Ducker

### 3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced W

6.(b) Name of husband or wife. George E. Ducker  
6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) January 27 1857  
8. AGE: Years 91 Months 0 Days 27 If less than one day..... hrs. .... min.

9. Birthplace..... Baltimore Md  
(Town, county, and state)  
10. Usual occupation..... Housewife

11. Industry or business -

MOTHER FATHER  
12. Name..... John Tinkler  
13. Birthplace..... England  
14. Maiden name..... Anna Haskard  
15. Birthplace..... England

16. Informant..... Miss Hattie Tinkler  
Address..... 75 Main St Reisterstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof. Feb 27 1948  
(month) (day) (year)  
Cemetery or crematory..... Trinity Lutheran Cemetery  
Location..... Reisterstown Md

18. Funeral director..... Wm Berryman & Sons  
Address..... Reisterstown Md

19. 2-26-48 19. 48 Mary B. Eline  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 24 1948 at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-24-1937 to 1937 and that I last saw her alive on Feb 23 1948

Immediate cause of death..... Arteriosclerotic C-V Disease 3 yrs  
DURATION

Due to.....  
Due to.....

Other conditions..... Cataracts 6 yrs  
(Include pregnancy within 3 months of death)

Major findings of operations..... None Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... None Date of .....  
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)  
Means of injury Injured at work?

23. SIGNATURE..... D. D. Caples, M.D.  
M. D. or other  
Address..... Reisterstown Md Date signed..... 2-26-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 1 1948

BUREAU V. S.

94/a

## 44

Reg. Diat. No. ....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01366

Reg. Dist. No.

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(if outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

Veterans Administration HospitalHow long in hospital or institution? 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Dundalk  
(if outside city or town limits, write RURAL and give nearest town)Street No. 24 Midship Road  
(if rural, give LOCATION)2.(a) If veteran, name war WW

## 3. (a) FULL NAME

HARRY T. ELMORE

## 3. (b) Social Security Number

Unknown

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Mrs. Mary Elmore7. Birth date of deceased (mo., day, yr.) January 16, 1894  
6. (c) If alive, give age 41 years

8. AGE:	Years	Months	Days	It less than one day
	<u>54</u>	<u>0</u>	<u>21</u>	.....hrs. ....min.

9. Birthplace Ohio  
(Town, county, and state)10. Usual occupation Clerk

11. Industry or business

12. Name Edward M. Elmore13. Birthplace Ohio14. Maiden name Margaret Andrews15. Birthplace Ohio16. Informant Clinical Records, Vet. Adm. Hosp.Address Fort Howard, Md.17. Burial Date thereof Feb. 9, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director Roland FisherAddress 2112 Dundalk Ave. Balto. Md.19. 2/7 48 Arthur M. Smulson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 19 48 at 5:40 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1 19 48 to February 6 19 48and that I last saw him alive on February 6 19 48Immediate cause of death  
TUBERCULOSIS, PULMONARY, BILATERAL, 6 yrs.  
FAR ADVANCED, ACTIVE plus

Due to

Due to

Other conditions Hemorrhoids, Internal and External Unknown  
(include pregnancy within 3 months of death)

Major findings of operations

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

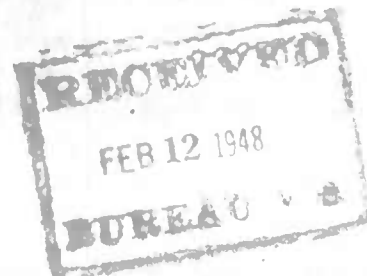
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.C. Manough  
H.C. MANAUGH, M.D., Chief, Professional Serv.  
Address VAH, Ft. Howard, Md. Date signed 2/6/48





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01367

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Stansbury Estates  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Stansbury E states  
 City or town Stansbury E states  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1410 Shore Rd  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Harry Milton Engelbrecht

## 3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) It alive, give age. — years  
 7. Birth date of deceased (mo., day, yr.) March 30 - 1885

8. AGE: Years 62 Months 10 Days 28 If less than one day  
 hrs. min.

9. Birthplace Baltimore - Ind.  
 (Town, county, and state)

10. Usual occupation Merchant11. Industry or business German12. Name Charles Engelbrecht13. Birthplace Germany14. Maiden name Catharine Glumman15. Birthplace Germany16. Informant Mrs. Lauren A. MechauAddress 1410 Shore Rd. Stansbury E states17. Burial Date thereof March 2 - 48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ParkwoodLocation Balto Md.18. Funeral director Ans. C. Muller Inc.Address 2435 E. Oliver St.19. 2/28 48 A.W. Hedrich

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 1948 at 1:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dec 6, 1947 to January 16, 1948  
 and that I last saw him alive on January 26, 1948

Immediate cause of death CoronaryArteriosclerosisHeart DiseaseArteriosclerosisHeart DiseaseArteriosclerosisHeart DiseaseArteriosclerosisHeart DiseaseArteriosclerosisHeart DiseaseArteriosclerosisHeart DiseaseArteriosclerosisHeart DiseaseArteriosclerosisHeart DiseaseArteriosclerosisHeart DiseaseArteriosclerosisHeart DiseaseArteriosclerosisHeart DiseaseArteriosclerosisHeart DiseaseArteriosclerosisHeart DiseaseArteriosclerosisHeart DiseaseArteriosclerosisHeart Disease

## DURATION

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 106 W. Main St. Rd. Date signed 2-27-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

01368

44

## 1. PLACE OF DEATH:

County..... BaltoCity or town..... Chase Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Box 583

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... BaltoCity or town..... Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. Box 583  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

William Harry Ewing

## 3. (b) Social Security Number

213-07-2326

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Denise L. (Shifflett)

7. Birth date of deceased (mo., day, yr.)

Nov. 22 - 1893

8. AGE:

Years

54

Months

2

Days

22

If less than one day

..... hrs. .... min.

9. Birthplace

Augusta Co. Va.  
(Town, county, and state)

10. Usual occupation

Blacksmith

11. Industry or business

James Ed. Ewing

12. Name

Ireland

13. Birthplace

Mummie Belle Beckes

14. Maiden name

Va

15. Birthplace

Mrs. Denise L. Ewing

16. Informant

Address Chase Md. Box 58317. Removal

(Burial, cremation, or removal, Which?)

Date thereof 2-17-48

(month) (day) (year)

Cemetery or crematory Mt. Mariah Cem.Location Virginia

18. Funeral director

Address John B. Connolly488 Eastern Ave.19. 2/16/48

(Date rec'd by registrar)

19. John B. Connolly

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13/48 19....., at 6:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death

Myocarditis  
Crowned Arteries

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John B. Connolly  
John B. Connolly  
Address..... Date signed 2/13/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 17 1948

BUREAU N. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

01369

48

## 1. PLACE OF DEATH:

County BaltimoreCity or town Eves  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Eves  
(If outside city or town limits, write RURAL and give nearest town)Street No. Cherry Garden Rd. Route 13  
(If rural, give LOCATION) Balto. 21

2. (a) If veteran, name war

## 3. (a) FULL NAME

Herbert W. Ey Sr.

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Ethel V. Ey

## 6. (c) If alive, give age..... years

## 7. Birth date of

deceased (mo., day, yr.)

March 10-1898

## 8. AGE:

49

Years

10

Months

26

Days

It less than one day

hrs. min.

## 9. Birthplace

Balto. Md.

(Town, county, and state)

## 10. Usual occupation

Police Man

## 11. Industry or business

## FATHER

## 12. Name

Edward Ey

## 13. Birthplace

Md.

## MOTHER

## 14. Maiden name

Margaret Michealman

## 15. Birthplace

Balto. Md.

## 16. Informant

Ethel V. Ey

## Address

Cherry Garden Rd. Route 13

## 17. Burial

(Burial, cremation, or removal) Which?

## Date thereof

Feb. 7-48

(month) (day) (year)

## Cemetery or crematory

Oak Lawn Cem.

## Location

Eastern Ave.

## 18. Funeral director

## Address

John E. Miller  
2334 Jefferson St.

## 19.

(Date rec'd by registrar)

2648Dw Hedrich

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1948 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1947 to Feb 4 1948and that I last saw him alive on Feb 4 1948Immediate cause of death Pulmonary  
edema & Cardiac Arrest

## DURATION

Due to CachexiaDue to advanced metastatic  
CarcinomaOther conditions Carcinoma of left  
kidney diagnosed 2 years ago  
at the Johns Hopkins Hospital.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE

John E. Miller M.D.

M. D. or other

Address 901 Cherry Rd. Balto 20 Date signed 5 Feb 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

01370

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville 28, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 32 yrs. 8 mos. 24 das.  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 32 yrs. 8 mos. 24 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Dorch.  
 City or town Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John Finlay

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) 1881  
 8. AGE: Years 67 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Dorchester County Md  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business Agriculture  
 12. Name Am B. Finlay  
 13. Birthplace Ireland  
 14. Maiden name Elizabeth Shannon  
 15. Birthplace Ireland

16. Informant Hospital Records  
 Address Catonsville 28, Maryland  
 17. Burial Date thereof Feb 21 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory David Ridge  
 Location Fikesville Md  
 18. Funeral director Henry W. Jenkins & Sons, Inc  
 Address McCulloch Orchard St  
 19. Feb 20 1948 A.W. Fedrue  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 19, 1948 at 6:30 a.m.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_  
 Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Cardiac failure  
 Due to \_\_\_\_\_  
Cardio vascular disease  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Geo. S. McKieffer M. D. or other \_\_\_\_\_  
 Address 1010 Linden Date signed 2/19/48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

County Baltimore  
City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 months  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Baltimore  
City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 43 Township Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Margaret Fitzpatrick

## 3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced W.6. (b) Name of husband or wife Patrick Fitzpatrick7. Birth date of deceased (mo., day, yr.) August 8, 1866  
6. (c) If alive, give age years8. AGE: Years 81 Months 5 Days 25 If less than one day  
hrs. min.9. Birthplace Pennsylvania  
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name William Mullin13. Birthplace Ireland14. Maiden name Mary Holleran15. Birthplace Pa.16. Informant Mrs. Adrian PaluskiwiczAddress 43 Township Road, Dundalk, Md.17. Removal Date thereof Feb. 5, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sacred HeartLocation Williamstown, Pa.18. Funeral director Roland L. FisherAddress 2112 Dundalk Ave.19. 2/3 19 48 Miriam M. Drummond  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH 2-2-48 19 48 at 7:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-20- 19 48, to 2-2- 19 48.and that I last saw him alive on 2-2- 19 48.Immediate cause of death Cerebral Thrombosis DURATION 1 weekDue to Hypertension arteria ?Self-induced cardio-vascularDue to diseaseGeneral arterio-sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Eugene F. New M.D.Address 7001 Phoenix Station Rd D. or otherDate signed 2-3-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01371

93d





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

01372

30

### 1. PLACE OF DEATH:

County.....Baltimore.....

City or town.....Catonsville.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 8 mos. 6 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 2 yrs. 8 mos. 6 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland..... County.....Baltimore.....

City or town.....Baltimore.....  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1727 E. Oliver Street

(If rural, give LOCATION)  
World War I

2.(a) If veteran, name war.....

### 3. (a) FULL NAME

James Fleckenstein

### 3. (b) Social Security Number

James M. Fleckenstein

#### 4. Sex

male

#### 5. Color or race

white

#### 6. (a) Single, married, widowed, or divorced

divorced

### 6. (b) Name of husband or wife

Marie Desort

#### 7. Birth date of deceased (mo., day, yr.)

August 7, 1895

#### 5. (c) If alive, give age

x years

#### 8. AGE:

Years

Months

Days

If less than one day

52

6

8

hrs.

min.

### 9. Birthplace

Baltimore, Maryland

(Town, county, and state)

### 10. Usual occupation

Clerk

### 11. Industry or business

MOTHER FATHER

#### 12. Name

Adam Fleckenstein

#### 13. Birthplace

Germany

#### 14. Maiden name

Margaret Mueller

#### 15. Birthplace

Germany

### 16. Informant

Mrs. Sophia Herbert

#### Address

1219 East Chase St., Balto., Md.

### 17.

Burial Date thereof 2 18 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

#### Cemetery or crematory

Balto. National

#### Location

Frederick Rd

### 18. Funeral director

Dippel Bros

#### Address

1800 E. Lombard St

### 19.

2/17 48 A.W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 19 48 at 5:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 29, 1945 19 48 to Feb. 15 19 48

and that I last saw him alive on February 15 19 48

#### Immediate cause of death

Cirrhosis of liver

#### DURATION

3 yrs.

#### Due to

#### Due to

#### Other conditions

(Include pregnancy within 3 months of death)

#### Major findings of operations

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

#### Means of injury

#### Injured at work?

### 23. SIGNATURE

Isadore Tuerk, M.D.

M. D. or other

Catonsville 28, Md.

Date signed 2-15-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information concerning the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

01373

42

## 1. PLACE OF DEATH:

County BaltCity or town Halethorp  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4420 Poplar ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltCity or town Halethorp  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4420 Poplar ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

John Franz

7. Birth date of deceased (mo., day, yr.)

July 1917

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

306

hrs.

min.

9. Birthplace

Baltimore  
(Town, county, and state)

10. Usual occupation

Home

11. Industry or business

HomeFATHER  
MOTHER

12. Name

Albert S. Treub

13. Birthplace

md

14. Maiden name

Margaret v

15. Birthplace

md

16. Informant

John FranzAddress 4420 Poplar ave

17.

(Burial, cremation, or removal, Which?)

Date thereof

July 6, 48  
(month) (day) (year)

Cemetery or crematory

London Park

Location

Baltimore

18. Funeral director

Harry H. Ditzke

Address

4401 Edmondson Ave

19.

(Date rec'd by registrar)

July 5-48Gutierrez

Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

February 3, 1948 at 5-45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

DURATION

Suicide

Due to

Due to

Chlorinating gas

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

suicide Date of July 3, 48

Where did injury occur?

Halethorp Baltimore md  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

gar fire range in kitchen Injured at work July 3, 48

23. SIGNATURE

Geo S. McKieffer Deed Med

M. D. or other

Address

1010 Leeds ave

Date signed

2-3-48

Recd  
8/17/48  
+ 1000



Evidence for addition of usual residence of deceased shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 114 APR 6 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County... 16 Frostburg are Catonsville md.

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)

State... md. County.....

City or town... Catonsville Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 Frostburg are  
(If rural, give LOCATION)

2411 W. Rogers Ave.

3. (a) FULL NAME

Esther Fried

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

Female white Widow

6. (b) Name of husband or wife..... Late Louis

7. Birth date of deceased (mo., day, yr.)..... 1863

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.  
84

9. Birthplace..... Hungary  
(Town, County, and State)

10. Usual occupation.....

11. Industry or business..... none

12. Name..... unknown

13. Birthplace..... Hungary

14. Maiden name..... unknown

15. Birthplace..... Hungary

16. Informant..... Harry Fried

Address..... 1903 W Rogers are

17. Burial..... Burial Date thereof..... Feb-13/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Balto Hebrew Cemety

Location..... Belair Road

18. Funeral director..... Sal Lerman Bros

Address..... 1124 W. North are

19. 2/12 1948 D.W. Hedlund  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 11 1948 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... Jan 4 1948 to..... Feb 11 1948

and that I last saw him/her alive on..... February 11 1948

Immediate cause of death.....

Cerebral Hemorrhage DURATION..... 5 hrs

Due to..... Generalized Arteriosclerosis DURATION..... 15 yr?

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE..... William K. Talley M.D.

Address..... Catonsville 28 rd M. D. or other

Date signed..... 2-12-48

MARGIN RESERVED FOR BINDING

VS A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01375

Reg. Dist. No. 33

### 1. PLACE OF DEATH.

County BALTIMORE  
City or town REISTERSTOWN, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Feb. 19, 1948  
Hospital, institution, or street address where death occurred:  
MT. PLEASANT SANATORIUM  
How long in hospital or institution? from Feb. 19, 48

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County \_\_\_\_\_  
City or town BALTIMORE  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 147 N. MONTFORD AVE  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

BENJAMIN FRIEDMAN

### 3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife \_\_\_\_\_  
6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 1892?

8. AGE: Years 56? Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace LITHUANIA  
(Town, county, and state)

10. Usual occupation TAILOR

11. Industry or business \_\_\_\_\_

12. Name JOSEPH

13. Birthplace LITHUANIA

14. Maiden name ROSE LEVINE

15. Birthplace LITHUANIA

16. Informant Samuel Friedman

Address 147 N. Montford Ave

17. Burial Rosedale Date thereof 2-22-48  
(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or place of interment Philp Rd. Hamilton Ave

Location Jack Lewis Inc

18. Funeral director 2600 Eutaw Place

Address 2-24 19 48 a.w. Hedrich  
(Date rec'd by Registrar) Registrar pu T

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20, 1948 at 5:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 19, 48 to Feb 20, 48 and that I last saw him alive on Feb 20, 48

Immediate cause of death MYOCARDIAL FAILURE

Due to FAR ADVANCED PULMONARY TUBERCULOSIS 1 year

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Antopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE CECIL RUDNER, M.D.  
M. D. or other \_\_\_\_\_  
Address MT. PLEASANT SANATORIUM Feb 20, 48  
REISTERSTOWN, Md

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.



FEB 24 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

01376

39

Reg. Dist. No. ....

1. PLACE OF DEATH  
 County..... Baltimore  
 City or town..... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 2 yrs.  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants, give residence of mother)  
 State..... Maryland County..... Baltimore  
 City or town..... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... no

3. (a) FULL NAME Jacob Elwood Fuller

3. (b) Social Security Number  
217-09-7237

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married  
 6. (b) Name of husband or wife..... Hilda Blanche Grimm  
 6. (c) If alive, give age..... 45 years

7. Birth date of deceased (mo., day, yr.)..... May 1899  
 8. AGE: Years..... 49 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... Sparks, Baltimore G. Md.  
 (Town, county, and state)

10. Usual occupation..... Chauffeur

11. Industry or business..... Cabbie

12. Name..... Jacob Fuller

13. Birthplace..... Parkton R.D.

14. Maiden name..... Cora Hoover

15. Birthplace..... Westminster, Md.

16. Informant..... Jacob Fuller

Address..... Parkton, Md.

17. Burial..... Date thereof..... Feb. 12, 1948  
 (month) (day) (year)

Cemetery or crematory..... Pine Grove

Location..... Parkton R.D.

18. Funeral director..... Howard A. Haskins

Address..... White Hall, Md.

19. 2/14/48 19..... Anna Price  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 9 19..... 48 at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death..... Heart disease, chronic DURATION.....

vascular. Coronary occlusion, S. 2/9/48

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: \_\_\_\_\_

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Baltimore / Tucker MD. DME

M. D. or other

Address..... Towson Md. Date signed..... 2/9/48.

RECEIVED

FEB 17 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01378

### 1. PLACE OF DEATH:

County Baltimore  
City or town Glenarm Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Dessie Giffin

### 3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug 16 - 1878  
6. (c) If alive, give age 69 years

8. AGE: Years 69 Months 5 Days 24 If less than one day hrs. min.

9. Birthplace Md.  
(Town, county, and state)

10. Usual occupation Stockkeeper

11. Industry or business

12. Name Benj F. Giffin

13. Birthplace Md.

14. Maiden name Eliza Hale

15. Birthplace Md.

16. Informant Mrs. Albert W. Cole

Address Perry Point Md.

17. Burial Date thereof Feb 13 - 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Trinity Episcopal

Location Longgreen Md.

18. Funeral director Clarence T. Arthur

Address Fork Md.

19. Feb 13 19 48 C. E. Arthur  
(Date rec'd by registrar) Deputy Foral Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balt.

City or town Glenarm Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 11, 1948 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8, 1945 to Feb. 11, 1948  
and that I last saw him alive on Feb 9, 1948

Immediate cause of death Cerebral Hemorrhage DURATION 10 min.

Due to Hypertensive Cardiac 3 yrs.

Vascular Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Clifford F. Hudson Md.

23. SIGNATURE Fork Md. M. D. or other

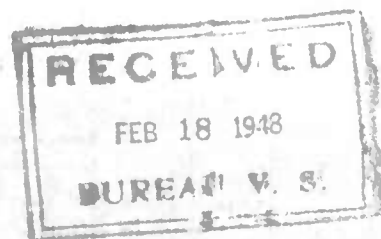
Address 2/12/48 Date signed

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01378

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County... *Baltimore*City or town... *Spawns Pt*  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *20 yrs*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Lallie Gladney*

## 3. (b) Social Security Number

4. Sex

*F*

5. Color or race

*C*

6. (a) Single, married, widowed, or divorced

*m*

6. (b) Name of husband or wife

*Earnest*

7. Birth date of deceased (mo., day, yr.)

*Aug. 31-1900*

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

*47**6**13*

..... hrs.

..... min.

9. Birthplace

*Woodward S.B.*

(Town, county, and state)

10. Usual occupation

*Domeshe*

11. Industry or business

FATHER

12. Name

*Thomas Irving*

13. Birthplace

*S.B.*

MOTHER

14. Maiden name

*Dolly Wylie*

15. Birthplace

*S.B.*

16. Informant

*Earnest Gladney*

Address

*808 J. St*

17. (Burial, cremation, or removal, Which?)

Date thereof

*2-17-48*  
(month) (day) (year)

Cemetery or crematory

*Red Hill*

Location

*Samuel 60 S.B.*

18. Funeral director

*Samuel W. Sullivan Jr*

Address

*1011 N. Arlington Ave - Balto*

19.

*Feb 15- 19 48*

(Date rec'd by registrar)

*Dawson L. Harbor*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

*MD*

County

*Balto*

City or town

*Spawns Pt*  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

*808 J. St*  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*February 14*19. *48*at *5 P.* A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*June*19. *47**Feb 14*19. *48*

and that I last saw her alive on

*Feb 13*19. *48*

Immediate cause of death

*Cardio respiratory failure on week due to thrombosis*

DURATION

Due to *Generalized Carcinoma of 6 mo*Due to *Primary Carcinoma of breast indefinite*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

*Primary Carcinoma of left breast*

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*Dawson L. Harbor M.D*

M. D. or

Address

*Spawns Point, Md.*

Date signed

*2/15/48*



RECEIVED

FEB 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County Balto  
 City or town Monkton  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Balto County Balto  
 City or town Monkton  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Josephine Guido  
 4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) August 31, 1897 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 50 Months 5 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Italy  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Lewis Pitrelli13. Birthplace Italy14. Maiden name Angela Scomarco15. Birthplace Italy16. Informant Lewis PitrelliAddress 3920 Charmant St17. Burial Date thereof 2-26-48

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. StanislausLocation Summerville Rd.18. Funeral director John G. MoranAddress 3000 E. Balt. St.19. 2/25 19 48 A.W. Geduch

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 19 48 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19 48 Feb 23 19 48and that I last saw him alive on Feb 22 19 48Immediate cause of death Valvularheart disease

DURATION

4 years

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Milner Boston Dr. W.Address White Hall Date signed Feb 24, 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 39

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Jacksonville (Phoenix P.O.)  
 (If outside city or town limits, write RURAL and give nearest town)

How long to above place of death? 52 yrs.

Hospital, institution, or street address where death occurred:

Stansbury Mill + Manor Roads

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Jacksonville (Phoenix P.O.)  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Stansbury Mill + Manor Rds.

(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

LEWIS HANNIBAL, SR.

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Lena Schulte Hannibal6. (c) If alive, give age 82 years

## 7. Birth date of

deceased (mo., day, yr.)

March 3, 1854

## 8. AGE:

Years

Months

Days

If less than one day

93912— hrs.— min.

## 9. Birthplace

Germany

(Town, county, and state)

## 10. Usual occupation

Retired

## 11. Industry or business

Farmer

## FATHER

## 12. Name

Unknown

## 13. Birthplace

"

## MOTHER

## 14. Maiden name

Unknown

## 15. Birthplace

"

## 16. Informant

Arthur Hannibal

## Address

Phoenix P.O., Md

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Feb. 17, 1948

(month) (day) (year)

## Cemetery or crematory

Jacksonville Reformed

## Location

Jacksonville, Balto. Co., Md.

## 18. Funeral director

John Burrows Sons

## Address

Towson, Md

## 19. Date

Feb. 16, 1948

(Date rec'd by registrar)

Anna Price

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 1948, at 5:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 6 1948, to Feb. 11 1948and that I last saw him alive on Feb. 11 1948

Immediate cause of death

Myocardial chronic

DURATION

?

Due to

Due to

Other conditions

Gangrene of both legs  
and poor circulation

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

T. G. & D. G. & Co., Inc.

M. D. or other

Address Cashayville - MdDate signed 2/15/48Feb. 18, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01381

Reg. Dist. No. 43

## 1. PLACE OF DEATH:

County Balto.City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Belair Rd & Overlea ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto.City or town Balto. 6.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 9 E. Elm ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Leo Ruigg Hanrahan

## 3. (b) Social Security Number

090-07-7166

## 4. Sex

M.

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Phyllis Terne

## 6. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

Dec 23 1905

## 8. AGE:

Years 42Months 2Days 6

## If less than one day

hrs. min.

## 9. Birthplace

Balto.  
(Town, county, and state)

## 10. Usual occupation

clerk

## 11. Industry or business

## FATHER

## 12. Name

Joseph H. Hanrahan

## 13. Birthplace

Addison New York

## MOTHER

## 14. Maiden name

Minnie L. Martin

## 15. Birthplace

Ireland

## 16. Informant

Phyllis F. Hanrahan

## Address

9 E. Elm Ave

## 17. (Burial, cremation, or removal, Which?)

BurialDate thereof 3 3 48  
(month) (day) (year)

## Cemetery or crematory

Lorraine Park Cem.

## Location

Windsor Mill Rd.

## 18. Funeral director

Dippel Bros

## Address

7110 Belair Rd

## 19. (Date rec'd by registrar)

3/1

## 19. (Date rec'd by registrar)

Dr A.W. Dedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 1948 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19.....10.....19.....

and that I last saw him alive on Dec 19.....

Immediate cause of death

Cerebral reduction

Due to

chronic alcoholism

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Dr. A.W. Dedrick M. D. or otherAddress Belair Rd Date signed 2/29/48

## DURATION

5 yrs.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01382 37

## 1. PLACE OF DEATH:

County BaltimoreCity or town Shaw n, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 yrs.Hospital, institution, or street address where death occurred:  
Childs Rehabilitation InstituteHow long in hospital or institution? 6 years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Shaw n  
(If outside city or town limits, write RURAL and give nearest town)Street No. Childs Rehabilitation Institute  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Peggy Harris

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21, 19398. AGE: Years Months Days If less than one day  
8 11 23 4 hrs. min.9. Birthplace Manilla Phillipine Islands  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Hunter Harrison13. Birthplace Fort Sam Houston Texas14. Maiden name Margaret Bostie15. Birthplace Ohio16. Informant Hunter HarrisAddress Maxwell Field Ala.17. Burial Date thereof Feb 17, 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington Nat. CemeteryLocation Arlington Va.16. Funeral director John O. MitchellAddress 1900 East ave Place19. Feb. 15 19 48 W. C. Van Horn  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 19 48, at 11 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 45, to Feb 13 19 48, and that I last saw him alive on Feb 7 19 48.Immediate cause of death Aspiration of vomitus

DURATION

10 minDue to Convulsions 8 yearsDue to Epilepsy 8 yearsOther conditions Cerebral palsy 8 yearsSpastic paralysis (Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

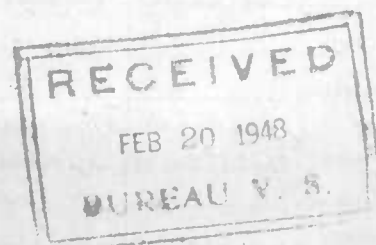
23. SIGNATURE Wilson Quill M. D. or otherAddress 4 B. 33rd St. Date signed 2/14/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## CERTIFICATE OF DEATH

Registered No. 2179

2179

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland *Parkway*  
 (b) Street address *6800 Belair Rd. at Northern*  
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) *26*

(c) Length of stay in Baltimore (yrs., mos., or days)

## 3 (a) FULL NAME

*George P HASKE*

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

*M*

5. Color or race

*W*

6 (a) Single, married, widowed, or divorced.

*DIVORCED*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

*1899*

8. AGE:

Years

Months

Days

If less than one day

*49*

hr.

min.

9. Birthplace

*D.C.*

(Town, county, and state)

10. Usual Occupation

*Automotive Engineer*

11. Industry or business

FATHER

12. Name

*GEO. B. HASKE*

13. Birthplace

*D.C.*

MOTHER

14. Maiden Name

*MARGARET PETRIE*

15. Birthplace

*SCOTLAND*

16 (a) Informant

*FRANK J. P. HASKE*

(b) Address

*CHICAGO, ILL.*

17 (a)

*Burial*

(b) Date thereof

*Mar. 2, 48*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

*St. Olives*

Location

*Washington D.C.*

18 (a) Funeral director

*Francis Collins*

(b) Address

*3821-14th St. N.W. Wash. D.C.*

19 (a)

*FEB 28 1948*

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE OF DECEASED:

(a) State *MD.* (b) County *BALTO.*  
 (c) City or town *Baltimore - 6*  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. *4310 Springwood Ave.*  
 (If rural give location)  
 (e) Citizen of foreign country? (Yes or No)  
 If yes, name country *✓*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb. 27* 19*48*, at *11* M

21. I certify that I took charge of the remains described above, held an

*Autopsy* thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to

*his* death on the day stated above, and death in myopinion resulted from: natural causes ☐ accident ☒ suicide ☐homicide ☐ undetermined ☐ and that the causes of death were:

## IMMEDIATE CAUSE OF DEATH

*Suffocation from inhalation of smoke*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury *2/27/48* at *?* A. M.(b) Where did injury occur? *Parking lot - 6800 Belair Rd. Northern Parkway*(c) Did injury occur at home, on farm, industrial place, in public place? *Auto* While at work? *NO*(d) Means of injury *Auto on fire*

23. Signature

*George C. Merrill M.D.*

Medical Examiner

Date signed

*2/27/48*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 35

### 1. PLACE OF DEATH:

County Parke - Balto. Co., Md.  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? transient  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penn. County Willkes Barre  
City or town Willkes Barre  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 36 Duhring St.  
(If rural, give LOCATION)  
2. (a) If veteran, name war ✓

### 3. (a) FULL NAME

Wm. P. Hawk

### 3. (b) Social Security Number

209-16-2978

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Marion Richards Hawk

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1927

8. AGE: Years 20 Month 6 Day 5 If less than one day..... hrs. .... min.

9. Birthplace Swyersville Pa.  
(Town, county, and state)

10. Usual occupation ? Unemployed

11. Industry or business

12. Name William Hawk

13. Birthplace Willkes-Barre, Pa.

14. Maiden name Bertha Marinka

15. Birthplace Swyersville Pa.

16. Informant Mrs. Marion A. Hawk

Address Willkes-Barre, Pa.

17. Removal Date thereof..... (month) (day) (year)

Cemetery or crematory St. Mary's Russian Con.

Location Balto. Co. - Hwy to Willkes-Barre

18. Funeral director William J. Dickner & Son

Address North & Penn. Aves Balto. Md.

19. Feb. 28, 1948 Registrar Mrs. Howard S. Maxline

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26, 1948 at 2:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death..... DURATION

Fractured skull

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Feb 26, 1948

Where did injury occur? York St. & Duhring St. Balto. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Road

Means of injury Automobile in which deceased was a passenger

Injured at work? collided head on with truck 2411/45 at

23. SIGNATURE A. M. France

Address Parke, Md. M. D. or other 2/26/48

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 2 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Evidence for change of  
usual residence shown on:

FILM No. G 114 APR 1 1948

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

Baltimore

County

Stoneleigh

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Armacost Nursing Home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Baltimore

City or town

Stoneleigh Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

812 Register ave. Charles &amp; Lafayette St.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

ANNE VIRGINIA HAYDEN

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Edwin P. Hayden

7. Birth date of  
deceased (mo., day, yr.)

6. (c) If alive, give age..... years

1865

8. AGE:

Years

Months

Days

If less than one day

83

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

Unknown

MOTHER FATHER

12. Name

"

13. Birthplace

Unknown

14. Maiden name

"

15. Birthplace

16. Informant

Robert N. Baer, Esq.

Address

306 Baltimore Life Bldg.

17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof 2/12/48

(month) (day) (year)

Cemetery or crematory

Druid Ridge

Location

18. Funeral director

Address

Chas. G. Evans, Son Inc.  
118 N. Mt. Royal Ave.

19.

2/10/48

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19.

Registrar

23. SIGNATURE

Address

M. D. or other

Date signed 2/10/48

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 1948 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 15 1947 to Feb 6 1948

and that I last saw him alive on Feb 6 1948

Immediate cause of death

Coronary occlusion

DURATION

Sudden

Due to

Artery occlusion

Due to

a hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed 2/10/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01385

Reg. Dist. No. 43

## 1. PLACE OF DEATH:

County..... Balto  
 City or town..... Balto 6 Rosedale  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Rt 40 + 64 St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD County.....City or town..... Balto 46  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1506 Odell Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married

6.(b) Name of husband or wife..... Grace M. Heinle

7. Birth date of deceased (mo., day, yr.)..... Dec. 25th, 1902  
 6.(c) If alive, give age..... years

8. AGE: Years..... 45 Months..... 1 Days..... 8  
 If less than one day..... hrs. .... min.

9. Birthplace..... Baltimore, Md.  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business..... Eastern Rolling Mill

FATHER 12. Name..... John F. Heinle  
 13. Birthplace..... Baltimore, Md.

MOTHER 14. Maiden name..... Louise Sraver  
 15. Birthplace..... Baltimore, Md.

16. Informant..... Mrs. J.H. Heinle  
 Address..... 1506 Odell Ave., Rosedale

17. burial Date thereof..... Feb 7 48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Oak Lawn  
 Location..... Baltimore, Md.

18. Funeral director..... Lanahan Funeral Home.  
 Address..... 7401 Belair Road

19. 2/5 85 D.W. Hedrick  
 (Date rec'd by registrar) (year) (Signature) Registrar

## 3. (b) Social Security Number

212-01-9206

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 3 48 at 4:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....  
 and that I last saw h..... alive on.....19.....

Immediate cause of death.....

Coronary accident  
 Due to.....  
 Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

SIGNATURE..... Dr. Hedrick M. D. or other  
 Address..... Balto. Co. Denton Date signed..... 2/3/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01386

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville 28, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 13 years  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 13 years

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2709 Frederick Road.  
(If rural, give LOCATION)  
2. (a) If veteran, name war .....

### 3. (a) FULL NAME

Annie Heiser

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Mr. Charles A. Heiser  
1825 Wilhelm St. 6. (c) If alive, give age ..... years  
7. Birth date of deceased (mo., day, yr.) May 4, 1878  
8. AGE: Years Months Days If less than one day  
69 9 3 ..... hrs. .... min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 19 48 at 12:10 A.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
September 15 19 47 to Feb. 7 19 48  
and that I last saw him er alive on Feb. 6 19 48  
Immediate cause of death Chronic myocarditis

### DURATION

years

Due to .....  
Due to .....  
Other conditions Generalized arteriosclerosis years

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. ....

Autopsy results .....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide ..... Date of .....  
Where did injury occur? ..... (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) .....  
Means of injury ..... Injured at work?

23. SIGNATURE Ethel B. Zimmerman Dr.  
Spring Grove Hospital M. D. other  
Address Catonsville 28 Md. Date signed 2-7-48

9. Birthplace Scotland  
(Town, county, and state)  
10. Usual occupation Housework  
11. Industry or business .....  
12. Name George W. Ray  
13. Birthplace Scotland  
14. Maiden name Catherine McKlarney  
15. Birthplace Ireland  
18. Informant Mr. Charles A. Heiser, husband  
Address 1825 Wilhelm St. Baltimore, Md.  
17. Burial Date thereof 2/10/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematorium St. Mary's Hospital  
Location Baltimore Md.  
18. Funeral director Frank H. Smith  
Address 814 N. 36th St.  
19. 2/10/48 19 48  
(Date rec'd by registrar) Registrar D. W. Hedrick

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2 trans

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01387

Reg. Dist. No. 3/

1. PLACE OF DEATH: Baltimore Co.  
 County Harrissonville  
 City or town \_\_\_\_\_  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? \_\_\_\_\_  
 Hospital, institution, or street address where death occurred: \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3004 Evergreen Avenue  
 (If rural, give LOCATION) ✓  
 2.(c) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Louis T. Heying

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife Catherine M.  
 7. Birth date of deceased (mo., day, yr.) Feb. 7th, 1870 8. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 78 Months 0 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Germany  
 (Town, county, and state)  
Retired  
 10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_  
 12. Name ?  
 13. Birthplace ?  
 14. Maiden name ?  
 15. Birthplace ?

16. Informant Mrs. Catherine Parks  
 Address 3004 Evergreen Avenue  
 17. Burial 2-21-48  
 (Burial, cremation, or removal. Which?) \_\_\_\_\_ Date thereof \_\_\_\_\_ (month) (day) (year)  
 Cemetery or crematory Holy Cross  
 Location Brooklyn, Maryland  
 18. Funeral director Leonard J. Ruck  
 Address 5305 Harford Road, 14

19. 2/18/48 19 48 Tom E. Martin  
 (Date rec'd by registrar) \_\_\_\_\_ Registrar

## MEDICAL CERTIFICATION

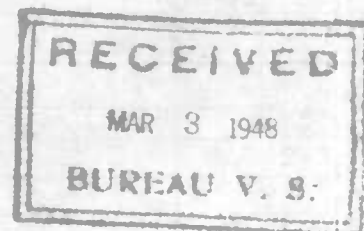
20. DATE OF DEATH Feb. 19, 1948 at 6 a M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 11, 1948 to Feb. 18, 1948  
 and that I last saw him alive on Feb. 18, 1948

Immediate cause of death Cardio Vascular Disease  
 DURATION \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underlines the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Tom E. Martin M. D. or other \_\_\_\_\_  
 Address Randallstown Date signed 2/18/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01388

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County BaltimoreCity or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 20 Waldron Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Jennie D. Hines

## 3.(b) Social Security Number

4. Sex

F.

5. Color of race

W.

6.(a) Single, married, widowed, or divorced

W.

6.(b) Name of husband or wife

Isaac W.

7. Birth date of deceased (mo., day, yr.)

Sept 23, 1875

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

7249

hrs.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

George Nicholson

13. Birthplace

Baltimore, Maryland

MOTHER

14. Maiden name

Minnie Harrington

15. Birthplace

Maryland

16. Informant

Mr. J. J. Bragler

Address

20 Waldron Ave

17.

(Burial, cremation, or removal. Which?)

Date thereof

2-14-48  
(month) (day) (year)

Cemetery or crematory

Waldron

Location

Waldron, Maryland

18. Funeral director

James J. Bragler

Address

5005 John Adams Ave

19.

(Date rec'd by registrar)

19 48Dr. E. E. Nichols

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb. 1, 1948 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JAN.19 45

to

FEB. 119 48and that I last saw him alive on Feb. 15 19 48

Immediate cause of death

DURATION

Chronic Myocarditis2 wks.

Due to

Coronary Thrombosis2 wks.

Due to

Art. Sclerosis2 yrs.

Other conditions

Hypertension5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James J. Bragler

M. D. or other

Address

Pikesville, Md

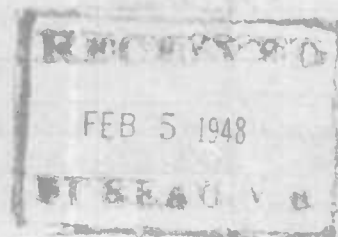
Date signed

2/4/48

To  
Dr. Miller  
Then to Dr. Nichols  
for Burial Permit

Per 40 Miller

9 40 - Harry



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01383 f

## 1. PLACE OF DEATH:

County Balto.  
 City or town Stoneleigh  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 wks  
 Hospital, institution, or street address where death occurred:  
7100 Oxford Rd.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Balto.  
 City or town Stoneleigh  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 7100 Oxford Rd.  
 (If rural, give LOCATION)  
 2.(a) 11 veteran, name war

## 3. (a) FULL NAME

MINNIE M. HOLSTON

## 3. (b) Social Security Number

no

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widow  
 6.(b) Name of husband or wife Charles Carroll Holston  
 7. Birth date of deceased (mo., day, yr.) July 24, 1861 6.(c) If alive, give age ..... years  
 8. AGE: Years 86 Months 6 Days 7 If less than one day ..... hrs. .... min.

9. Birthplace Baltimore, Md.  
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Skipper

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant Mr. Arthur E. HolstonAddress 7100 Oxford Rd.

17. Burial Date thereof 2/4/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Druid Ridge Cem.Location Pikesville, Md.18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.

19. 2-3 48  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 19 48 at 5:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN 15 19 48 to FEB 1 19 48  
 and that I last saw H.E.R. alive on FEB 1 19 48

Immediate cause of death Cerebral Hemorrhage - Left side  
a left Hemiplegia complete  
ARTERIO-SCLEROSIS  
 Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. C. P. M. D. M. D. or other

Address 6805 York Road Date signed 2/2/48

Registrar



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01390

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

20 Seminole Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 20 Seminole Ave.  
(If rural, write LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

FRANK C. HORLEBEIN

## 3.(b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6.(a) Single, married, widowed, or divorced

widower

6.(b) Name of husband or wife Lydia Horlebein

6.(c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

Aug. 22, 1862

## 8. AGE:

Years

Months

Days

If less than one day

85

5

18

hrs.

min.

9. Birthplace Balto., Md.

(Town, county, and state)

10. Usual occupation Retired Stone Cutter

## 11. Industry or business

12. Name Horlebein13. Birthplace Germany14. Maiden name Unknown15. Birthplace Germany16. Informant Mr. Edwin W. HorlebeinAddress 20 Seminole Ave., Catonsville17. Burial Date thereof 2/12/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Paul's Cem.Location Violetville, Md.18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. 2/11/48 19  
(Date received by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10/48 19 48 at 5:00a M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 2 19 48 to Feb 10 19 48and that I last saw him alive on Feb 9 19 48Immediate cause of death Cerebral Infarction

DURATION

Due to 10 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. O'Connell M. D. or otherAddress 612 N. 40 St. Date signed

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 57

01391

93d

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Cockeysville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... Life  
 Hospital, institution, or street address where death occurred:  
Sherwood Road  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Baltimore  
 City or town..... Cockeysville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Sherwood Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Emma Jane Howard

## 3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Widowed  
 6.(b) Name of husband or wife..... J. Frank Howard  
 8.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... March 18, 1865  
 8. AGE: Years..... 84 Months..... 10 Days..... 2 If less than one day..... hrs. .... min.

9. Birthplace..... Baltimore County, Md.  
 (Town, county, and state)  
 10. Usual occupation..... Housewife  
 11. Industry or business..... home  
 12. Name..... William Hedrick  
 13. Birthplace..... Baltimore Co., Md.  
 14. Maiden name..... Mary Funk  
 15. Birthplace..... Balto. Co., Md.

18. Informant..... Leroy Howard  
 Address..... Cockeysville, Md.  
 17. Burial  
 (Burial, cremation, or removal. Which?) Date thereof..... 2-22-48  
 (month) (day) (year)  
 Cemetery or crematory..... Poplar Grove  
 Location..... Cockeysville, Md. (Warren)  
 18. Funeral director..... Dandon M. Brooks  
 Address..... Sparks, Md.  
 19. 2-21..... 48..... Wilmer C. Engor  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 20 1948 at 2<sup>30</sup> A. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Oct 10 - 1945 to 2/19 1948  
 and that I last saw her alive on 2/19 1948.  
 Immediate cause of death..... Myocarditis  
Arterio sclerosis  
Senility  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

## DURATION

3 yrs.

Major findings of operations.....  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... Wilmer C. Engor M.D.  
 Address..... Cockeysville Md. Date signed 2/20/48

RECEIVED

FEB 26 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01392

Reg. Dist. No. 35

### 1. PLACE OF DEATH:

County Baltimore  
City or town Rural near Parkton  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 27 yrs.  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Rural near Parkton  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3 mi. North of Parkton  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Alice Margaret Hunt

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed or divorced Married

6. (b) Name of husband or wife Clarence W. Hunt

6. (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) November 20, 1888

8. AGE: Years 59 Months 3 Days 9 If less than one day  
.....hra. ....min.

9. Birthplace Maryland Line, Md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Mathias Thomas

13. Birthplace Germany

14. Maiden name Hester Keys

15. Birthplace Freeland, Md.

16. Informant Clarence W. Hunt

Address Parkton, Md. R.D.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof March 3, 1948  
(month) (day) (year)

Cemetery or crematory Mt. Zion Cemetery

Location Freeland, Md.

18. Funeral director Jacob Hartman's

Address New Freedom Pa.

19. Mar 3 1948 Charles J. Fisher Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 29 1948 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1947 to Feb. 29 1948  
and that I last saw her alive on Feb. 29 1948

Immediate cause of death Carcinoma of stomach

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of stomach

Date of op. May 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. France M. D. or other

Address Parkton, Md. Date signed 2/21/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 11 1948

BUREAU V. S.

Correct residence obtained by phone...3/5/48 am

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Maryland State

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 01393 30

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 16 Fusting Ave.

(c) Hospital or institution:

House in the Catonsville

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Catonsville  
(If outside city or town limits, write RURAL and give town)(d) Street No. 16 Fusting Ave. 2535  
(If rural give location)(e) Citizen of foreign country? (Yes or No)  
If yes, name country

## 3 (a) FULL NAME

FANNIE HUTCHINSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Sidney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1873

8. AGE: Years 74 Months 2 Days 5 If less than one day hr. min.

9. Birthplace Orange Co. Va.  
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Sidney Gillium

13. Birthplace England

14. Maiden Name Sarah

15. Birthplace

16 (a) Informant Mrs. Nellie H. Farrar

(b) Address 2535 Calverton Hgts

17 (a) Removal (b) Date thereof 2/6/48  
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Graham Cem.  
Location Orange, Va.

18 (a) Funeral director Wm. J. Tickner &amp; Sons

(b) Address North &amp; Pa. Aves.

19 (a) 2/6/48 (b) A. J. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 5, 1948, at 8 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5 1946, to 2-5 1948, and that I last saw him alive on Feb. 4, 1948.

Immediate cause of death

Congestive myocardial  
decompensation  
Due to Chr. Hypertensive  
cardio-vascular disease

Duration

24 hr.

Due to

15 hr.

Other Conditions

(Include pregnancy within 3 months of death)  
Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Melvin K. Gallagher, M.D.  
M. D.

Address Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01394

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 years, 9 months, 5 days  
 Hospital, institution, or street address where death occurred:  
 Spring Grove State Hospital  
 How long in hospital or institution? 3 years, 9 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County.....  
 City or town..... Baltimore-11  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 911 West 37th Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Mary Elizabeth Jean

## 3. (b) Social Security Number

4. Sex..... female  
 5. Color or race..... white  
 6.(a) Single, married, widowed, or divorced..... widowed

6.(b) Name of husband or wife..... Joseph H. Jean

7. Birth date of deceased (mo., day, yr.)..... October 21, 1861  
 6.(c) If alive, give age..... years

8. AGE: Years..... 86 Months..... 3 Days..... 17 If less than one day..... hrs. .... min.

9. Birthplace..... Baltimore, Maryland  
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... Home

12. Name..... Theodore Pinkler

13. Birthplace..... Germany

14. Maiden name..... Barbara Deam

15. Birthplace..... Germany

16. Informant..... Hospital records

Address..... Catonsville-28, Maryland

17. Burial Date thereof 2/11/48  
 (Burial, cremation, or removal of body?) (month) (day) (year)

Cemetery or crematory..... London Park

Location..... Balto. Md.

18. Funeral director..... Williams Cook Inc.

Address..... 1217 St. Paul St.

19. 2/10/48 19 A. W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 7 1948 at 4:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 1944 to February 7 1948  
 and that I last saw her alive on February 7 1948

Immediate cause of death..... Pseudobulbar paralysis 1 week  
 Generalized arteriosclerosis years  
 Due to..... Hypertensive cardiovascular disease II

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Isadore Tuerk, M.D.

23. SIGNATURE..... Isadore Tuerk, M.D.

Address..... Catonsville-28, Md.

Date signed..... 2-9-48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **38**

01395

### 1. PLACE OF DEATH:

County **Baltimore**  
City or town **Loch Raven**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? **at home**  
Hospital, institution, or street address where death occurred: **at home**  
How long in hospital or institution? **at home**

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State **md.** County **Balto.**  
City or town **Loch Raven**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. **Crimmell Bridge Road**  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

**Robert Moore Jennifer**

### 3. (b) Social Security Number

4. Sex **Male** 5. Color or race **white** 6. (a) Single, married, widged, or divorced **Single**  
6. (b) Name of husband or wife **none**

7. Birth date of deceased (mo., day, yr.) **October 29-1879** 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years **68** Months **3** Days **14** less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace **Balto. Md.**  
(Town, county, and state)

10. Usual occupation **Clark Court House -**

11. Industry or business **Tolson Md.**

12. Name **Thomas R. Jennifer**

13. Birthplace **Balto. Md.**

14. Maiden name **Margaret Moore**

15. Birthplace **Balto. Co. Md.**

16. Informant **Walter M. Jennifer - (Brother)**

Address **Loch Raven - Md.**

17. Burial (Burial, cremation, or removal, Which?) **Burial** Date thereof **Feb. 15-48**  
(month) (day) (year)

Cemetery or crematory **Prospect Hill**

Location **Tolson - Md.**

18. Funeral director **Stewart Home Company**

Address **108 W. North - Balto. Md.**

19. **Feb 13** 19 **48** (Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH **February 12<sup>th</sup>** 19 **48** at **9 P.** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Apr.** 19 **47** to **Feb 12<sup>th</sup>** 19 **48**  
and that I last saw him alive on **Feb 11<sup>th</sup>** 19 **48**

Immediate cause of death **Coronary Thrombosis** DURATION **Instant**

Due to **Arterio Sclerosis**

Due to **Mitral Insufficiency** 15 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Daniel O. R. Jennifer M.D.** M. D. or other

Address **Tolson & Md** Date signed **2/13/48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 21 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01396

Reg. Dist. No. 44

### 1. PLACE OF DEATH:

County Balto

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

607 Dorsey Ave.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No. 607 Dorsey Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Almeda Jenkins

### 3. (b) Social Security Number

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

William Jenkins

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Apr. 9th - 1893

8. AGE:

Years

Months

Days

If less than one day

54

10

1

hrs.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

at home

FATHER

12. Name

James A. Wiley

13. Birthplace

Virginia

MOTHER

14. Maiden name

James E. Cooksey

15. Birthplace

Virginia

16. Informant

William Jenkins

Address

607 Dorsey Ave.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 14 - 48

Cemetery or crematory

Oak Lane Cem

Location

Eastern Blvd.

18. Funeral director

John S. Connolly

Address

418 Eastern Blvd.

19.

(Date rec'd by registrar)

2-13-48  
John S. Connolly  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH

February 10<sup>th</sup> 1948 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 1947 to Feb. 10, 1948

and that I last saw her alive on Feb. 10, 1948

Immediate cause of death

Hypostatic PNEUMONIA.  
HEART FAILURE.

Due to

Malnutrition

Due to

Adeno CARCINOMA of  
the uterine cervix

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Maxwell M. Munn

M. D. or other

Address 417 1/2 Eastern Ave. Date signed 2-12-48.

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for change of  
birthdate shown on  
Film G114 3/4/48 dm  
Doctor's Letter.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1068 PC 01397  
Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 yrs. 6 mos.  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 2 years 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County ---  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2409 W. Lexington  
(If rural, give LOCATION)  
2.(a) If veteran, name war ✓

3. (a) FULL NAME

Walter H. Jenkins

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed  
6.(b) Name of husband or wife Ruth ~~Edith~~ Jenkins (deceased)  
6.(c) If alive, give age 16 years  
7. Birth date of deceased (mo., day, yr.) December 19, 1892 Aug. 16, 1898  
8. AGE: Years 47 Months 4 Days 12 If less than one day, give hrs. 16 min. 1900  
9. Birthplace Virginia  
(Town, county, and state)  
10. Usual occupation odd jobs  
11. Industry or business ---

12. Name Robert P. Jenkins  
13. Birthplace Virginia  
14. Maiden name Linda Wharton  
15. Birthplace Virginia

16. Informant Mr. Linwood Jenkins  
Address 2409 W. Lexington St. Balt. 23 2-  
17. Burial Date thereof March 2, 1948  
(Burial, cremation, or removal, which?)  
Cemetery or crematory Shiloh Cemetery  
Location King George Vay.  
18. Funeral director Charles J. Schwab  
Address 3512 Frederick Ave.  
19. 3/1 19 48  
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 19 48 at 11:55A M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 17 19 45, to Feb. 28 19 48  
and that I last saw him alive on February 28 19 48  
Immediate cause of death Cachexia

Due to Bronchiectasis DURATION 2 yrs  
Due to years  
Other conditions ---  
(Include pregnancy within 8 months of death)

Major findings of operations --- Date of op. ---  
Autopsy results ---  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide --- Date of ---  
Where did injury occur? --- (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) ---  
Means of injury --- Injured at work? ---  
23. SIGNATURE Isidore Fink, M.D. M. D. or other ---  
Spring Grove State Hosp Address --- Date signed Feb. 28/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01398

Reg. Dist. No. 35

### 1. PLACE OF DEATH:

County... Baltimore  
City or town... Monkton (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?... Lifetime  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Baltimore  
City or town... Monkton (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Big Falls Road  
(If rural, give LOCATION)  
2. (a) If veteran, name war... no

### 3. (a) FULL NAME

Robert Clarence Johnson

### 3. (b) Social Security Number

220-12-9932

4. Sex M 5. Color or race Colored 6. (a) Single, married, widowed, or divorced single

### 6. (b) Name of husband or wife

6. (c) If alive, give age... years

T. Birth date of deceased (mo., day, yr.) Oct. 28, 1926

8. AGE: Years 21 Months 3 Days 12 If less than one day... hrs. min.

9. Birthplace Cockeysville, Md.  
(Town, county, and state)

10. Usual occupation... W. A. S. A.

11. Industry or business Masonic Home - Cockeysville

12. Name John Lewis Johnson

13. Birthplace Baltimore, Md.

14. Maiden name Emily Maryman Hall

15. Birthplace Baltimore, Md.

16. Informant Mrs. J. Lewis Johnson

Address Monkton, Md.

17. Burial Date thereof Feb. 12, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Luke's

Location Monkton P.O. (Harford) Md.

18. Funeral director London M. Daniels

Address Sparks, Md.

19. Feb. 14 19 48 Mrs. Howard S. Markline  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 9 February 19 48 at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 February 19 48 to 9 February 19 48 and that I last saw him alive on 7 February 19 48

Immediate cause of death Pneumonia DURATION 4 days

Due to Tuberculosis 6 mo.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op.

Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

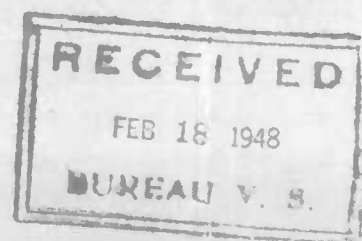
23. SIGNATURE Walter T. Kees M.D. M. D. or other

Address Cockeysville, Md. Date signed 9 Feb. 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 01399 28

## 1. PLACE OF DEATH:

County... Baltimore  
 City or town... Baltimore in Town  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 months  
 Hospital, institution, or street address where death occurred:  
Mercy Villa  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... Balto.  
 City or town... Baltimore, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Bellona Ave  
 (If rural, give LOCATION) Former Res. ✓  
 2(a) If veteran, name war .....

## 3. (a) FULL NAME

LILLIE E. KELLY

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 8. AGE: Years About 80 Months  Days  It less than one day 1868 hrs.  min.   
 7. Birth date of deceased (mo., day, yr.) 1868  
 8. (b) Name of husband or wife .....

9. Birthplace... Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation... None  
 11. Industry or business .....

12. Name... Thomas Kelly  
 13. Birthplace... Ireland  
 14. Maiden name... Julia Williams  
 15. Birthplace... Baltimore, Maryland  
 16. Informant... S. R. Mears  
 Address... 805 N. Calvert Street

17. Burial Date thereof 2/16/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Cathedral  
 Location... Baltimore, Maryland  
 18. Funeral director... H. H. Weiss and Son  
 Address... 805 N. Calvert St.  
 19. 2-16-48 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Feb 13 1948 at 1:00 P M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 9, 1946 to Feb 13, 1948  
 and that I last saw him alive on Feb 12, 1948  
 Immediate cause of death... Coronary Thrombosis DURATION 10 min  
 Due to... Arterio-Sclerosis Diabetes  
Hypertension  
 Due to... Hypertension  
 Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations...  
 Date of op. ....

Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of ...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE... W H Kelly M. D. or other  
 Address... 1403 Park Ave Date signed... 2-14-48

Former residence obtained from Mercy Villa by phone 3-8-48 ams

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 hrs.

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, MarylandHow long in hospital or institution? 6 hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Brooklyn  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3616 - 3rd St.,

(If rural, give LOCATION)

2. (a) If veteran, name war WW I

## 3. (a) FULL NAME

PATRICK J. KENEALY

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife Single7. Birth date at deceased (mo., day, yr.) 2-22-94

8. (c) If alive, give age years

8. AGE: Year 53 Month 11 Day 22 If less than one day hrs. min.9. Birthplace Scranton, Pennsylvania  
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Decklin Kenealy13. Birthplace Ireland14. Maiden name Hanera Sullivan15. Birthplace England16. Informant Clinical Records, Vets. Adm. Hosp.  
Address Fort Howard, Maryland17. Removal 2-15-48  
(Burial, cremation, or removal: Which?) (month) (day) (year)Cemetery or crematory Hessinger Funeral HomeLocation Pittstown, Pa.18. Funeral director Howard N. Blight, Jr.Address 4914 Belair Rd., Baltimore, Md.19. Feb 15 19 48 J. J. Kennedy  
(Date filled in by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 19 48 10:55 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 14 19 48 to February 14 19 48and that I last saw him alive on February 14 19 48Immediate cause of death CARDIAC DILATATION  
AND HYPERTROPHY

DURATION

UnknownDue to Rheumatic Heart Disease  
(Mitral Valve)Unknown

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results: Substantiated Above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George Lemer MD M.D. or otherAddress V.A.H. Fort Howard, Md. Date signed 1-15-48

BUREAU A. S.

FEB 19 1948

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 01401 40

### 1. PLACE OF DEATH:

County Baltimore  
City or town Hotel Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Hotel Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Sister Mary Norberta Korff

### 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Single

6.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1862

8. AGE: Years Months Days If less than one day  
85 2 9 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace New York City  
(Town, county, and state)

10. Usual occupation Teacher

### 11. Industry or business

12. Name Charles Korff

13. Birthplace Germany

14. Maiden name Anna Fried

15. Birthplace Germany

16. Informant Sr. Mary Clara

Address Hotel Cliff

17. Burial Date thereof Mar 14 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Notch Cliff

Location Towson

18. Funeral director Geo M. Frankson

Address 811 N Wolfe St

19. Feb 28 48 Wm. Hammett  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1948, at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1946 to Feb 27 1948 and that I last saw her alive on Feb 25, 1948 1948

Immediate cause of death Carcinoma (Breast) DURATION 1 yr.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Wm. Hammett M. D. or other

Address Towson Date signed Feb 27 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 2 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

### 1. PLACE OF DEATH:

County Baltimore  
City or town Cockeysville Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 year - 10 Months  
Hospital, institution, or street address where death occurred:  
Mason's Home  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 220 S. Augusta Ave  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Louise Marie Kraft

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 30 - 1883 6. (c) If alive, give age years

8. AGE: Years 64 Months 9 Days 15 If less than one day hrs. min.

9. Birthplace Baltimore Md  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Wm. C. Kraft

13. Birthplace Baltimore

14. Maiden name Mary McWinch

15. Birthplace New York

16. Informant Laura M. Schroeder

Address Mason's Home, Cockeysville

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof Feb 14 - 48  
(month) (year)

Cemetery or crematory Baltimore Cemetery

Location Baltimore

18. Funeral director Wm. Cook

Address St. Paul & Preston St.

19. 2-14-48 19 L. M. Schroeder  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 19 48 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 47 to Feb 14 19 48

and that I last saw him alive on Feb 14 19 48

Immediate cause of death

Carcinoma Tosis

tosis

Due to

Carcinoma of Intestines

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Exploratory Laparotomy

Date of op. 10/29/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter J. Rees M.D.

Address Cockeysville Md Date signed 2/14/48

MARGIN RESERVED FOR BINDING

VS A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

FEB 17 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01403

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County BALTIMORE

City or town CATONSVILLE  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred OPITZ NURSING HOME

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County BALTIMORE

City or town CATONSVILLE  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 112 FOREST DRIVE  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

WILLY KROENCKE

### 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

WIDOWED

6.(b) Name of husband or wife

ALFRED OTTO KROENCKE

7. Birth date of deceased (mo., day, yr.)

SEPT. 11, 1857

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

90

5

25

hrs.

min.

9. Birthplace

GERMANY  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

ALEXANDER COONE

13. Birthplace

GERMANY

MOTHER

14. Maiden name

FREDERICKA ?

15. Birthplace

GERMANY

16. Informant

MR. JULIAN A. JENKEL

Address

PHONE - CATONSVILLE 699M

17.

(Burial, cremation, or removal, Which?)

Date thereof 2/28/48  
(month) (day) (year)

Cemetery or crematory

WOODLAWN

Location

BALTO. CO., MD.

18. Funeral director

WM. J. TICKNER & SONS

Address

NORTH & 1A. AVES. BALTO. MD

19.

(Date rec'd by registrar)

2/28 48

Amherst

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2/26 19 48 at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

DEC 20 19 46, to FEB 26 19 48

and that I last saw him alive on FEB 26 19 48

Immediate cause of death

Cerebral Hemorrhage

DURATION

10 days

Due to

Cerebral Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

23. SIGNATURE

James H. Houchens

M. D. or other

Address

Catonville

Date signed

2/27

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 23 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Maryland  
 How long in hospital or institution? 23 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1606 Mt. Royal Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW-I ✓

## 3. (a) FULL NAME

EARL C. KUHNS

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Divorced

6.(b) Name of husband or wife Divorced  
 B.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 12-1995

8. AGE: Years 52 Months 2 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cumberland, Maryland  
 (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business \_\_\_\_\_

12. Name Spence Kuhns

13. Birthplace Pennsylvania

14. Maiden name Theodora Bell

15. Birthplace Cumberland, Maryland

16. Informant Clinical Records, Vets. Adm. Hospital  
 Address Ft. Howard, Maryland

17. Removal Date thereof Feb 28, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Stein Funeral Home

Location 117 Frederick St., Cumberland, Md.  
Howard N. Blight, Jr.

18. Funeral director Howard N. Blight, Jr.  
 Address 4914 Belair Rd., Baltimore, Md.

19. Feb. 21 - 48 19 48  
 (Date rec'd by registrar) Registrar John J. Connelley

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 20, 19 48 at 11:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 28, 19 48 to February 20, 19 48

and that I last saw him alive on February 20, 19 48

Immediate cause of death Subdiaphragmatic abscess DURATION Unknown

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Undiagnosed inflammatory mass of stomach Unknown  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results Substantiated above.  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE P. H. Landers M.D. M. D. or other \_\_\_\_\_  
P.H. LANDERS, M.D.

Address V.A.H. FT. HOWARD, MD. Date signed 2-21-48

**RECEIVED**

MAR 3 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

01405

B 8

## 1. PLACE OF DEATH:

County BaltimoreCity or town Towson 4, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since October, 1947

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.How long in hospital or institution? Since Oct. 18, 1947

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto CityCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 134 Curley  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Mary Pagna

## 3.(b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Late Joseph Pagna

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) April 13, 18938. AGE: Years 54 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Italy (Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Sibartian ametta13. Birthplace Italy14. Maiden name Catharina Genanto15. Birthplace Italy16. Informant Personal History - Hospital RecordsAddress Eudowood Sanatorium, Towson 4, Md.17. Burial Date thereof March 3, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy Redeemer CemLocation Bdair Road18. Funeral director John A. MoranAddress 3000 E Baltimore St19. 3-2 48 Registering  
(Date rec'd by registrar) (Date signed by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 29, 1948 at 9:10 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18, 1947 to Feb 29, 1948and that I last saw him alive on February 28, 1948

Immediate cause of death

Pulmonary tuberculosis

Due to

Due to

Other conditions Disruptive KellgrenDiscovered on admission  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE N.B. Bridges M. D. or otherAddress Towson 4, Md. Date signed 2-29-48DURATION  
Since  
About  
May, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

01406

93d

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Rural-- Balto. Dunkirk  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1-1/2

Hospital, institution, or street address where death occurred:

How long in hospital or institution? --

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Rural-- Dunkirk Rd. ( Balto. )  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 609 Dunkirk Rd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

None

## 3. (a) FULL NAME

HOWARD JOSEPH LANGGOOD

## 3. (b) Social Security Number

?

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

--

7. Birth date of

deceased (mo., day, yr.)

Apr. 16, 1906

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

41922

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation Supervisor-- Bureau of Sanitation11. Industry or business Mayor & City Council12. Name Charles J. Langgood Sr.13. Birthplace Baltimore, Md.14. Maiden name Ellen E. Connelly15. Birthplace Baltimore, Md.16. Informant Mrs. De Wilton HasleysAddress 609 Dunkirk Rd.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 2/12/48

(month) (day) (year)

Cemetery or place of interment New CathedralLocation Baltimore, Md.18. Funeral director WM. J. TICKNER & SONS INC.Address Baltimore, Md.19. 2/11/48

(Date rec'd by registrar)

C. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8, 1948 19 48 at 10:25 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/9 19 47 to 2/8 19 48  
 and that I last saw him alive on 2/7 19 48

Immediate cause of death

Arteriosclerotic heart disease

DURATION

1 yr.

Due to

Due to

Other conditions

Pulmonary infection 3 wks.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. Edward Leach

M. D. or other

Address 14 E. Eager St Date signed 2/10/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01407 44

## 1. PLACE OF DEATH:

County... *Baltimore*  
 City or town... *Dundalk*  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

7806 Fairgreen Road, Dundalk

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *md* County... *Baltimore*City or town... *Dundalk*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *7806 Fairgreen Road*  
(If rural, give LOCATION)2.(a) If veteran, name war... *II*

## 3. (a) FULL NAME

*Harold Langston*

## 3. (b) Social Security Number

4. Sex

*m.*

5. Color or race

*w.*

6. (a) Single, married, widowed, or divorced

*m.*6. (b) Name of husband or wife... *Elizabeth P.M. Langston*

7. Birth date of deceased (mo., day, yr.)

*October 31, 1905*

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

*42**3**21*

hrs. min.

9. Birthplace

*New York, N. Y.*  
(Town, county, and state)

10. Usual occupation

*Unemployed*

11. Industry or business

MOTHER FATHER

12. Name

*Herbert Langston*

13. Birthplace

*England*

14. Maiden name

*Anna M.*

15. Birthplace

*Wales*

16. Informant

*Elizabeth P.M. Langston*

Address

*7806 Fairgreen Rd., Dundalk*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

*Feb. 24, 1948*

(month) (day) (year)

Cemetery or crematory

*Baltimore National Cema*

Location

*5501 Frederick Road*

18. Funeral director

*Roland L. Fisher*

Address

*2112 Dundalk Ave., Dundalk*

19. Feb 23 - 48

(Date rec'd by registrar)

*Dwight L. Fisher*

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... *Feb. 21* 19... *48* at *3:30 p.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

...19... to ...19...

and that I last saw him... alive on ...19...

Immediate cause of death

*Carbon Monoxide Poisoning*

DURATION

*18 hrs*

Due to

*(Illness - Gas)*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... *suicide* ...19... *2/21/48*

Where did injury occur?

*Dundalk - Baltimore*

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

*Home*

Means of injury

*Turned on gas*

Injured at work?

*no*

23. SIGNATURE

*M. B. Davis, M.D.*

Address

*Dundalk - Md.*Date signed... *2/23/48*



RECEIVED

FEB 25 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01408

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 19 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Fort Howard, Maryland  
 How long in hospital or institution? 19 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore (22) Dundalk  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1923 Queensway  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war Retired Army

## 3. (a) FULL NAME

JEROME A. LAWS

## 3. (b) Social Security Number

unknown

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Margaret Laws  
 6. (c) If alive, give age 67 years  
 7. Birth date of deceased (mo., day, yr.) 12-31-79  
 8. AGE: Years Months Days It less than one day  
68 1 3 hrs. min.

8. Birthplace Mt. Vernon, Kentucky  
 (Town, county, and state)  
 10. Usual occupation Unemployed (Retired) (Army)  
 11. Industry or business \_\_\_\_\_  
 12. Name John Laws  
 13. Birthplace Unknown  
 14. Maiden name Catherine Schmidt  
 15. Birthplace Unknown

16. Informant Clinical Records, Vets. Adm. Hosp.  
Ft. Howard, Maryland  
 Address \_\_\_\_\_

17. Burial Date thereof Feb 7, 1948  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory Baltimore National  
Baltimore, Md.  
 Location \_\_\_\_\_  
 18. Funeral director Roland L. Fisher  
 Address 2112 Dundalk Ave  
Meer M. Smulson  
Great Deputy Registrar

19. \_\_\_\_\_ 19 \_\_\_\_\_  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 19 48 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 16, 19 48 to February 4, 19 48  
 and that I last saw him alive on February 4, 19 48

Immediate cause of death  
Right sided cardiac dilatation  
and hypertrophy  
 Due to Emphysema, bilateral  
 Due to \_\_\_\_\_

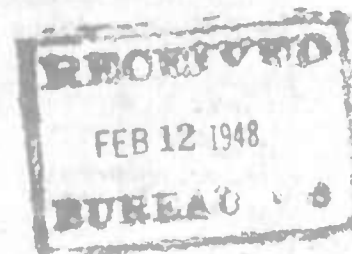
DURATION  
19 days  
plus

Other conditions Hypertension, Arterio-  
sclerosis generalized and Coronary  
Arteriosclerosis.  
 (Include pregnancy within 8 months of death)  
 Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results Substantiated above.  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE H.C. Manaul  
H.C. MANAUGH, M.D. Chief Professional Ser.  
 Address V.A.H. Fort Howard, Md. Date signed 2-5-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

01409

<b>1. PLACE OF DEATH:</b> <i>Baltimore</i> County..... City or town..... (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... City or town..... (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name War.....											
<b>3. (a) FULL NAME</b> <i>Solomon Leamon</i>				<b>3. (b) Social Security Number</b>											
<b>4. Sex</b> <i>M</i>		<b>5. Color or race</b> <i>Wh</i>		<b>6. (a) Single, married, widowed, or divorced</b> <i>Single</i>											
<b>6. (b) Name of husband or wife</b> <i>none</i>				<b>6. (c) If alive, give age</b> ..... years											
<b>7. Birth date of deceased (mo., day, yr.)</b> <i>October 8 1864</i>				<b>8. AGE:</b> <table border="1"> <tr> <td>Years</td> <td>Months</td> <td>Days</td> <td>If less than one day</td> </tr> <tr> <td>83</td> <td>4</td> <td>15</td> <td>hrs. min.</td> </tr> </table>				Years	Months	Days	If less than one day	83	4	15	hrs. min.
Years	Months	Days	If less than one day												
83	4	15	hrs. min.												
<b>9. Birthplace</b> <i>Pennsylvania</i> (Town, county, and state)				<b>10. Usual occupation</b> <i>Farmer</i>											
<b>11. Industry or business</b> <i>Agriculture</i>				<b>12. Name</b> <i>John Leamon</i>											
<b>13. Birthplace</b> <i>Pennsylvania</i>				<b>14. Maiden name</b> <i>Jane Smith</i>											
<b>15. Birthplace</b> <i>Pennsylvania</i>				<b>16. Informant</b> <i>Hospital records</i>											
<b>17. Address</b> <i>Catonsville 28 Md</i>				<b>18. Address</b> <i>Delta, Pa.</i>											
<b>19. (Burial, cremation, or removal. Which?)</b> <i>Burial</i>				<b>20. Date of death</b> <i>February 23 1948 at 10:45 A.M.</i>											
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <i>Sept 17 1941 to Feb 23 1948</i>				<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following:											
<b>23. Signature</b> <i>Henry C. Mead, M.D.</i>				<b>24. Address</b> <i>Catonsville 28 Md</i>											

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** *February 23 1948 at 10:45 A.M.*

**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from** *Sept 17 1941 to Feb 23 1948*

**and that I last saw him alive on** *Feb 23 1948*

**Immediate cause of death** *Myocardial failure & auricular fibrillation*

**Due to** *Coronary sclerosis*

**Due to** *Generalized arteriosclerosis*

**Other conditions** *Cachexia due to heart failure*

(Include pregnancy within 3 months of death)

**Major findings of operations**.....

**Autopsy results** *None*

**PHYSICIAN: Please underline the cause to which death should be charged statistically.**

**22. VIOLENCE:** If death was due to external causes, fill in the following:

**Accident, suicide, or homicide**.....

**Where did injury occur?**.....

**Injured at home, farm, industry, public place (where?)**.....

**Means of injury**.....

**Injured at work?**.....

DURATION

1 wk  
Suckling

"

"

RECEIVED

FEB 26 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01419

### 1. PLACE OF DEATH:

County Baltimore  
City or town Phoenix (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Lifetime  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town Phoenix (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Stansbury Mill Rd.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Philip Lins

### 3. (b) Social Security Number

#### 4. Sex

M.

#### 5. Color or race

W.

#### 6. (a) Single, married, widowed, or divorced

Married

#### 6. (b) Name of husband or wife

Estelle (nee Brown)

#### 7. Birth date of deceased (mo., day, yr.)

Aug 6, 1882

#### 6. (c) If alive, give age

62 years

#### 8. AGE:

Years

Months

Days

If less than one day

65

7

11

hrs.

min.

#### 9. Birthplace

Phoenix Maryland  
(Town, county, and state)

#### 10. Usual occupation

Carpenter & Farmer

#### 11. Industry or business

John C Lins

#### FATHER

#### 12. Name

John C Lins

#### 13. Birthplace

Germany

#### MOTHER

#### 14. Maiden name

Margaret Decker

#### 15. Birthplace

Germany

#### 16. Informant

Mr. Philip Lins

#### Address

Phoenix, Md.

#### 17.

(Burial, cremation, or removal, Which?)

#### Date thereof

Feb 19, 1948  
(month) (day) (year)

#### Cemetery or crematory

1st Reform Evng. Church

#### Location

Jacksonville, Balto. Co. Md.

#### 18. Funeral director

Landrum M. Bostick

#### Address

Sparks, Md.

#### 19.

(Date rec'd by registrar)

Feb 19, 1948

Anna Price

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1948, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 14 1948, to Feb 17 1948, and that I last saw him alive on Feb 14 1948.

#### Immediate cause of death

Malnutrition

#### DURATION

#### Due to

intestinal carcinoma

#### Due to

#### Other conditions

(Include pregnancy within 8 months of death)

#### Major findings of operations

Date of op.

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

#### 23. SIGNATURE

Elizabeth B. Stenill, M.D.  
M. D. or other

Address

Cockeysville, Md. Date signed 2/17/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 21 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01411 38

1. PLACE OF DEATH:  
 County Baltimore  
 City or town 6400 Bellona Avenue  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Ma. County Baltimore  
 City or town 6400 Bellona Avenue  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Minnie F. Llufrío

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife William Llufrío  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) January 15, 1860  
 8. AGE: Years 88 Months 1 Days 2 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_

FATHER 12. Name John Curry  
 13. Birthplace Unknown  
 MOTHER 14. Maiden name Fannie  
 15. Birthplace Unknown

16. Informant Sister Cecelia Anna  
 Address Mercy Villa Nursing Home

17. Burial Date thereof Feb. 18, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Parkwood  
 Location Baltimore, Maryland

18. Funeral director Wm. Cook, Inc.  
 Address 1217 St. Paul Street, Baltimore

19. 2/18/48  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 17, 1948, 9:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3, 1947, to Feb. 17, 1948  
 and that I last saw him alive on Feb. 17, 1948

Immediate cause of death Arteriosclerotic Cardiac Vascular Disease  
 DURATION 5 yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE P. H. Curry, M.D.  
 M. D. or otherAddress 11 E. Chase St. Date signed 2/18/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01412 33

## 1. PLACE OF DEATH:

County Balto.City or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 46 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 630 Main St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Agnes Belle Logsdon

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife John C. Logsdon

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1868

8. AGE:

Years

Months

Days

If less than one day

79119

hrs.

min.

9. Birthplace Howard Co.  
(Town, county, and state)10. Usual occupation Housework

11. Industry or business

12. Name Robert T. Mercer13. Birthplace Md.14. Maiden name Amelia Howell15. Birthplace Long Island16. Informant Agnes Logsdon  
Address Reisterstown, Md.17. Burial Date thereof Feb. 5, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Druid RidgeLocation Balto. Co.18. Funeral director J.F. Eline & SonsAddress Reisterstown, Md.19. 2-5-48 Mary B. Eline  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1948 at 10:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 30 1943 to Feb 3 1948and that I last saw him alive on Feb 2 1948

Immediate cause of death

DURATION

arteriosclerotic C-V. Disease 1 yr.  
mitral insufficiency 4 yrs.  
obstructive jaundice 13 da.

Due to

Other conditions peptic gastric ulcer

(Include pregnancy within 3 months of death)

Major findings of operations Cholecystectomy  
for cholelithiasis Date of op. May 21 '47Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) None (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE A. D. Caples, Jr. M. D. or otherAddress Reisterstown, Md. Date signed 2-5-48

RECEIVED  
FEB 14 1948  
MCTF

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

01413

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 Yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 14 Nunnery Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary Catherine Lowe

## 3. (b) Social Security Number

none

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Wallace F. Lowe

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

June 30, 1870

## 8. AGE:

Years

Months

Days

If less than one day

77713

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

Howard Co., Md.

(Town, county, and state)

## 10. Usual occupation

At Home

## 11. Industry or business

FATHER

## 12. Name

Albert A. Norton

## 13. Birthplace

Dayton, Ohio

MOTHER

## 14. Maiden name

Cordelia Cochran

## 15. Birthplace

Ireland

## 16. Informant

Mrs. Henry H. Good

## Address

14 Nunnery Lane, Catonsville

## 17.

Burial  
(Burial, cremation, or removal. Which?)Date thereof 2-16-48  
(month) (day) (year)

## Cemetery or crematory

Lorraine Park

## Location

Woodlawn, Md.

## 18. Funeral director

J. Howard Strong

## Address

3207 W. North Ave.

## 19.

Feb 14 1948  
(Date rec'd by registrar)16Richard

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1948 at 9.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 29th 1948 to February 12th 1948  
and that I last saw him alive on February 12th 1948

Immediate cause of death

DURATION

Hemorrhage Cerebr.2 days

Due to

Hypertension Cerebr.several

Due to

Dilated Myocardiumyears

Other conditions

Dilated Myocardium

(Include pregnancy within 3 months of death)

Major findings of operations

no operation

Date of op.

Autopsy results

no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James E. Sisk

M. D. or other

Address

514 Catherine St.Date signed 2-13-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

FEB 26 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 136 01415 22

## 1. PLACE OF DEATH:

County BaltimoreCity or town Pentecost Ind.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Ind. Pleasant SanatoriumHow long in hospital or institution? 8 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 214 West Mulberry St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

HARRY Martick

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Florence Martick

7. Birth date of

deceased (mo., day, yr.)

January 15, 18816.(c) If alive, give age 64 years

8. AGE:

Years

Months

Days

If less than one day

6718

hrs.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual occupation

 Sailor

11. Industry or business

FATHER

12. Name

Morris Martick

13. Birthplace

Poland

MOTHER

14. Maiden name

?

15. Birthplace

Poland

16. Informant

Address

Florence Martick214 W. Mulberry Street

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

RosedalePhila Rd, Hamilton Ave

18. Funeral director

Address

Jack Lewis Inc2100 Ontario Place19. 2/25

(Date rec'd by registrar)

19. 48A.W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 23, 1948, at 10:25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 23, 1948, to Feb. 23, 1948and that I last saw him alive on Feb. 23, 1948

Immediate cause of death

Myocardial Failure

DURATION

Due to

Pneumonia5 days

Due to

Other conditions

Pulmonary Tuberculosis(Poland - Indiana)

(Include pregnancy within 3 months of death)

30 years

Major findings of operations

Autopsy results Consolidation of Right Lower Lobe.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. Proctor MD

M. D. or other

Address Pentecost Ind. Date signed 2/23/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01416

Reg. Dist. No. 33

### 1. PLACE OF DEATH:

County Baltimore  
City or town Owings Mills  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 month, 12 days  
Hospital, institution, or street address where death occurred:  
29 Ritters Lane  
How long in hospital or institution? \_\_\_\_\_

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County \_\_\_\_\_  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 303 East 22nd St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3.(a) FULL NAME

Israel Griffith Mathews Jr

### 3.(b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced S

6.(b) Name of husband or wife \_\_\_\_\_  
6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 4 November 1877

8. AGE: Years 70 Months 3 Days 22 if less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Howe de Grace, Md.  
(Town, county, and state)

10. Usual occupation C.P.A. (Retired)

11. Industry or business U.S. Fidelity & Guaranty Co.

12. Name Israel Griffith Mathews

13. Birthplace Greenwood, Md.

14. Maiden name A. Helen Dappington

15. Birthplace Aberdeen, Md.

16. Informant Henry Mathews

Address Owings Mills, Md.

17. Burial Date thereof 2/28/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Grave

Location Aberdeen Md.

18. Funeral director Wm. J. Siggers & Sons

Address North & A. Aves.

19. 2/27/48 19 A. W. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 26 February 19 48 at 6:20 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 Jan. 19 48 to 26 Feb. 19 48 and that I last saw him alive on 26 Feb. 19 48

Immediate cause of death Bronchopneumonia

Due to Carcinoma pancreas with metastasis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Charles H. Williams M.D.

M. D. or other \_\_\_\_\_

Address Pikeville 8, Md. Date signed 26 Feb 48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01417

Reg. Dist. No. 7/

### 1. PLACE OF DEATH:

County Baltimore  
City or town Burner Station  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 yrs  
Hospital, institution, or street address where death occurred:  
205 Hendricks St  
How long in hospital or institution? 2 yrs

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For infants give residence of mother)  
State MD. County Baltimore  
City or town Burner Station  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 205 - Hendricks Ct.  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Gussie Maxwell

### 3. (b) Social Security Number

4. Sex + 5. Color or race C 6. (a) Single, married, widowed, or divorced 2

6. (b) Name of husband or wife Wm Maxwell

7. Birth date of deceased (mo., day, yr.) March 21, 1893 6. (c) If alive, give age 48 years

8. AGE: Years 54 Months 0 Days 0 It less than one day 0 hrs. 0 min.

9. Birthplace Augusta Ga.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Wm. Davies

13. Birthplace Ga.

14. Maiden name Mattie Allen

15. Birthplace Ga.

16. Informant Maggie Keel

Address 509 Thompson's Ct.

17. Burial Date thereof 2/19-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Calvary

Location A. Halstead

18. Funeral director 918 - Almid Hill Ave.

Address

19. 2/18 48 Registrar

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 19 48 at 11 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 48 to Feb 16 19 48  
and that I last saw him alive on 2-13-48

Immediate cause of death Hypertensive Heart Disease  
a failure

Due to usual

Due to usual

Other conditions none

(Include pregnancy within 8 months of death)

Major findings of operations none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

SIGNATURE Arthur L. Johnson MD

Address 423 N. P. Johnson M.D. or other

Date signed 2-16-48

MARGIN RESERVED FOR BINDING

9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

01418

40

## 1. PLACE OF DEATH:

County BaltimoreCity or town Notch Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Notch Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Sister Mary Clementine McCormick

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FemaleWhiteSingle

6. (b) Name of husband or wife .....

6. (c) If alive, give age .....

7. Birth date of

deceased (mo., day, yr.)

June 26, 1869

8. AGE:

Years

Months

Days

If less than one day

78726

hrs.

min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation Housework

11. Industry or business

FATHER  
MOTHER12. Name James McCormick13. Birthplace Baltimore, Md.14. Maiden name Anna Weigert15. Birthplace Bavaria Germany16. Informant Sr. Mary ClaraAddress Notch Cliff17. Burial Date thereof Feb 25/48  
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory Notch CliffLocation near Towson18. Funeral director Rev. M. Francis HorneAddress 811 N Wolfe St19. Feb 24 1948 Walter M. Hammett  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1948 at 8:40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1944 to Feb 22 1948and that I last saw him alive on Feb 18 1948Immediate cause of death Apoplexy

DURATION

1 wk 5 days

Due to .....

Due to .....

Other conditions hypertension and arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE Walter M. Hammett M. D. or otherAddress Towson Date signed Feb 23/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 25 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01419

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH

County Balto.  
 City or town Spassons Pt. Balto #9  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Ketchum Lane  
 How long in hospital or institution? Johns Creek

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... County .....  
 City or town .....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)

2. (a) If veteran, name war .....

## 3. (a) FULL NAME

Anna F. Megroth

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Link, Megroth  
 7. Birth date of deceased (mo., day, yr.) July 21-1859  
 8. AGE: Years 90 Months ..... Days ..... If less than one day ..... hrs. .... min. ....  
 6. (c) If alive, give age ..... years

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9/48 at 6:45 PM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....  
 and that I last saw him ..... alive on ..... 19.....

Immediate cause of death Coronary accident DURATION Sudden

Due to .....  
 Due to .....  
 Other conditions .....  
 (Include pregnancy within 3 months of death)

Major findings of operations .....  
 Date of op. ....

Autopsy results .....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ..... Date of .....  
 Where did injury occur? ..... (City or town) ..... (County) ..... (State) .....  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury ..... Injured at work?

23. SIGNATURE Imberson M.D. M.D. or other  
 Address Balto. 1111 N. Charles St. Date signed 2/9/48

9. Birthplace Cambridge, Massachusetts  
 (Town, county, and state)  
 10. Usual occupation Homemaker  
 11. Industry or business .....  
 12. Name Isaac H. Bailey  
 13. Birthplace Mass  
 14. Maiden name Unknown  
 15. Birthplace 11  
 16. Informant A. A. Bailey  
 Address 4001 Hillen, Rd.  
 17. Burial Date thereof Feb. 12-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Moreland Park  
 Location Taylor Ave.  
 18. Funeral director John B. Connolly  
 Address 418 Eastern Ave.  
 19. 2-12-48 John B. Connolly  
 (Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 17 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 39

01420

### 1. PLACE OF DEATH:

County Baltimore

City or town Monkton (Rural)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Monkton (Rural)  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Manor Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war No

### 3. (a) FULL NAME

Annie Charlotte Miller

### 3. (b) Social Security Number

4. Sex F. 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife J. Alfred Miller

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1872

8. AGE: Years 75 Months 3 Days 11 If less than one day hrs. min.

9. Birthplace Harford Co., Md.  
(Town, county, and state)

10. Usual occupation Domestic & Housewife

11. Industry or business

12. Name Isaac Hall

13. Birthplace Harford Co., Md.

14. Maiden name Charlotte Brown

15. Birthplace Harford Co., Md.

16. Informant James Miller

Address Monkton, Md.

17. Burial Date thereof Feb. 17, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Int. Joy

Location Monkton, Maryland

18. Funeral director Sandra M. Brooks

Address Sparks, Md.

19. Feb. 16 19 48 Anna Price  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 19 48 at 10:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8 19 48, to Feb. 13 19 48

and that I last saw him alive on February 13 19 48

Immediate cause of death Lobar Pneumonia DURATION 8 days

Due to

Due to

Other conditions Chronic myocarditis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. G. H. Esq. Co. Rd. M. D. or other

Address Cockeysville - Md Date signed 2/14/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

01421

## 1. PLACE OF DEATH

County Baets CoCity or town 15 Maple ave Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baets CoCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 15 Maple ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John K Mowry, Sr.4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 16 1862 8. (c) If alive, give age 85 years8. AGE: Years 85 Months 0 Days 0 It less than one day 0 hrs. 0 min.9. Birthplace Pa.  
(Town, county, and state)10. Usual occupation retired11. Industry or business Dept of Mills12. Name John K Mowry13. Birthplace Pa.14. Maiden name Charlotte Fullerton15. Birthplace Ireland16. Informant Mr John K Mowry JrAddress 15 Maple ave Catonsville17. Burial Date thereof Feb 23 1948  
(Burial, cremation, or reburial. Which?) (month) (day) (year)Cemetery or crematory Family LotLocation Youngstown Ohio18. Funeral director Edw J Mac NabbAddress Catonsville Md19. Feb 21 1948 V E Harry  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 19 48 at 9:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 25 19 47 to Feb 19 19 48and that I last saw him alive on Dec 6 19 47Immediate cause of death Dissecting aneurysmthoracic aortaDue to arteriosclerosisgeneralized, severeOther conditions Branchitis, chronic

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (whers?)

Means of injury Injured at work?

23. SIGNATURE Stephen Lee Magness M.D.Address Catonsville 28, Md Date signed 3-20-48

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

AGE

SEX

HEIGHT

WEIGHT

TEMPERATURE

PULSE

BLOOD PRESSURE

RESPIRATIONS

DIAGNOSIS

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

SEX

DATE OF DEATH

WEIGHT

DATE OF DEATH

PULSE

DATE OF DEATH

RESPIRATIONS

DATE OF DEATH

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

SEX

DATE OF DEATH

WEIGHT

DATE OF DEATH

PULSE

DATE OF DEATH

RESPIRATIONS

DATE OF DEATH

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

SEX

DATE OF DEATH

WEIGHT

DATE OF DEATH

PULSE

DATE OF DEATH

RESPIRATIONS

DATE OF DEATH

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

SEX

DATE OF DEATH

WEIGHT

DATE OF DEATH

PULSE

DATE OF DEATH

RESPIRATIONS

DATE OF DEATH

RECEIVED  
FEB 23 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01422

Reg. Dist. No.

32

## 1. PLACE OF DEATH:

County BaltimoreCity or town Owings Mills  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? About 8 monthsHospital, institution, or street address where death occurred: Rosewood State Training School

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore CityCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2813 W. Lanvale Street  
(If rural, give LOCATION)2.(a) If veteran, name war unknown

## 3. (a) FULL NAME

George James Murray

## 3. (b) Social Security Number

287-05-4556

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Divorced

6.(b) Name of husband or wife

Divorced

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1896

8. AGE: Years Months Days If less than one day

618Dayshrs. min.

9. Birthplace

Johnstown, Pa.  
(Town, county, and state)

10. Usual occupation

Engineer

11. Industry or business

Rosewood State Training School

12. Name

George James Murray

13. Birthplace

Johnstown, Pa.

14. Maiden name

unknown

15. Birthplace

16. Informant

William Murray  
3918 Canada Southern Ave Toledo

Address

17. Burial Date thereof (month) (day) (year)

Feb. 5, 1948

(Burial, cremation, or removal, which?)

Cemetery or crematorium

Toledo Cemetery

Location

Toledo, Ohio.

18. Funeral director

Frank H. Newell

Address

Pikesville, Maryland.

19. Date rec'd by registrar

Feb 4 1948

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 19 48 at 9 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-4-'48 19 2-4-'48 19and that I last saw him alive on not seen alive 19

Immediate cause of death

Coronary Artery Disease

DURATION

3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

NONE

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

NONE

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Dr. D. D. Eaples, Med. Exam

M. D. or other

Address Reisterstown, Md. Date signed 2-4-'48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157d

01423

FILM No. G 114 MAR 8 1948

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

County... BaltimoreCity or town... Owings Mills  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 years 7 mos.

Hospital, institution, or street address where death occurred:

Rosewood State Training SchoolHow long in hospital or institution? 8 years 7 mos.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Midland, Allegh-  
any County, Md.City or town...  
(If outside city or town limits, write RURAL and give nearest town)Street No...  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Harry Harrison Myers

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

6- 5-29

8. AGE:

Years

Months

Days

If less than one day

17 18820

hrs.

min.

9. Birthplace

Lonaconing, Md.

(Town, county, and state)

10. Usual occupation

Inmate Rosewood School

11. Industry or business

FATHER

12. Name

William Myers

13. Birthplace

Moscow, Md.

MOTHER

14. Maiden name

Lina Green

15. Birthplace

Lonaconing, Md.

16. Informant

Institutional Records, Rosewood

Address

Owings Mills, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb. 27, 1948  
(month) (day) (year)

Cemetery or crematory

Rosewood

Location

Balto. Co.

18. Funeral director

J. F. Eline & Sons

Address

Reisterstown, Md.

19.

2-27- 19 48  
(Date rec'd by registrar)Mary A. Eline  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 19 48 at 12.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 26, 19 39 to Feb. 25 19 48and that I last saw him alive on Feb. 25 19 48

Immediate cause of death

Status Epilepticus  
Microcephalic idiot with  
symptomatic grand mal epilepsy

DURATION

BirthDue to and quadriplegiaBirth

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harry H. Butler

M. D. or other

Address

Owings Mills, Md.Date signed 2-25-48

RECEIVED

MAR 2 1943

BUREAU V. 8.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0142433

## 1. PLACE OF DEATH:

County BaltimoreCity or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Berryman's Lane

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. Berryman's Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Sadie R. Myers

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Frank B. Myers

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

December 15, 1879

8. AGE:

Years

Months

Days

If less than one day

68I27

hrs. mto.

9. Birthplace

Ellicott City, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

\*\*\*\*\*

FATHER

12. Name Richard R. Snouffer13. Birthplace Frederick, Md.

MOTHER

14. Maiden name Caroline Ginneman15. Birthplace Frederick, Md.

16. Informant

Mr. George R. Myers

Address

1424 W. 37th St.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

2/17/48

(month) (day) (year)

Cemetery or crematory

Loudon Park

Location

Frederick Road

18. Funeral director

Wm. J. Tickner & Sons

Address

North & Penna. Aves. Balto. Md.19. 2/16

(Date rec'd by registrar)

48A. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 19 48 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-13-48 19 48 to 2-13-48 19and that I last saw her alive on not seen alive 19

Immediate cause of death

Coronary Artery Disease about 1 year

Other conditions:

DiabetesHypertensive C-VD 10 yrs.Obesity

DURATION

10 yrs.10 yrs.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

none

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

NONE

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. D. D. Caples

M. D. or other

Address

Reisterstown, Md.

Date signed

2-13-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County BaltimoreCity or town Raspburg  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Raspburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war. ....

## 3. (a) FULL NAME

John T. Norris

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Helen Norris

6. (c) If alive, give age. .... years

## 7. Birth date of

deceased (mo., day, yr.) August 20, 1883

## 8. AGE:

64

Months

Days

If less than one day

hrs. .... min.

9. Birthplace Govens., Balto., Md.  
(Town, county, and state)10. Usual occupation Laborer

## 11. Industry or business

12. Name James Norris13. Birthplace Md.14. Maiden name Susie Kentv15. Birthplace Md.16. Informant Mrs. Helen NorrisAddress Raspburg, Balto., Co., Md.17. Burial Date thereof 2-18-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Auburn Cem.Location Baltimore, Md.18. Funeral director Mrs. Frances A. HemsleyAddress 578 W. Biddle St.19. 2/16 48 A. W. Hedrick  
(Date recd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 13, 1948 at 5:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1, 1948 to Feb 13, 1948  
and that I last saw him alive on Feb 13, 1948

Immediate cause of death

thrombosis

DURATION

Sudden

Due to

arterio-sclerotic  
cardio-vascular disease2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Mrs. Frances A. Hemsley  
M. D. or other  
Address Balto 6 Md Date signed 2-14-48

MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

01426

## 1. PLACE OF DEATH

County Baltimore Registration Dist. No. 38  
 Village or City Louison No. 466 St. 466 Ward 466  
 (If death occurred in a hospital or institution, give its NAME instead of street and number)  
 Length of residence in city or town where death occurred 45 yrs. 5 mos. 5 ds. How long in U.S. if of foreign birth? 45 yrs. 5 mos. 5 ds.

## 2. FULL NAME

John Thomas Norris If U. S. Veteran, specify WAR WAR  
 (a) Residence: No. Louison St. Louison Ward. Louison  
 (Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Lilly (nee Matthews)</u>		
6. DATE OF BIRTH (month, day, and year) <u>June 29, 1879</u>		
7. AGE <u>68</u>	Years <u>7</u>	Months <u>19</u>
8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Laborer</u>		9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) <u>Balto Co., Maryland</u>
13. NAME <u>John Norris</u>
14. BIRTHPLACE (city or town) (State or country) <u>Balto Co., Md.</u>
15. MAIDEN NAME <u>Rebecca Rogers</u>
16. BIRTHPLACE (city or town) (State or country) <u>Richmond, Va.</u>
17. INFORMANT <u>Mrs. Lilly Norris</u> (Address) <u>Louison, Md.</u>
18. BURIAL, CREMATION, OR REMOVAL Place <u>Buried</u> Date <u>Feb 21, 1948</u> <u>St. Lukes, Hospital, Md.</u>
19. UNDERTAKER (Address) <u>Louison, Md.</u>
20. FILED <u>Feb. 18, 1948</u> <u>John A. Norris</u> Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH <u>Feb. 18, 1948</u> (Month) (Day) (Year)
22. I HEREBY CERTIFY, That I attended deceased from <u>Aug 26, 1947</u> to <u>Feb 18, 1948</u> I last saw <u>him</u> alive on <u>Feb 17, 1948</u> ; death is said to have occurred on the date stated above, at <u>230 P.M.</u> The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows: <u>Broncho-pneumonia</u> <u>Terminal</u> <u>Carcinoma of Stomach</u> Other Contributory Causes of Importance:
Date of onset <u>2 days</u>

Name of operation none Date of none  
 What test confirmed diagnosis? none Was there an autopsy? none

## 23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? none Date of Injury none  
 Where did Injury occur? none  
 (Specify city or town, county and State)  
 Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury none  
 Nature of injury none

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify none  
 (Signed) Bennett A. Stow M. D.  
 (Address) Lutherville, Md.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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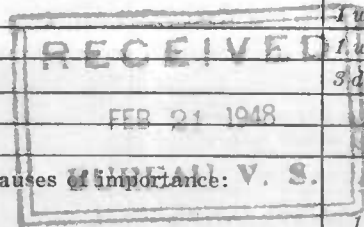
## Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attock of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01427

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville 28, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 yrs. 7 mos. 29 das.  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 2 yrs. 7 mos. 29 das.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Baltimore 7  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Johnny Cake Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

Nettie O'Conner

## 3. (b) Social Security Number

None

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Charles O'Conner  
 7. Birth date of deceased (mo., day, yr.) November 30, 1878  
 8. AGE: Years 69 Months 2 Days 26 It less than one day hrs. min.

9. Birthplace Virginia - Warren  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Domestic

12. Name Silas Pomeroy

13. Birthplace Virginia - Warren Co.

14. Maiden name Martha Lehue

15. Birthplace Virginia - Page, Co.

16. Informant Hospital Records

Address Catonsville 28, Md.

17. Burial Date thereof Feb. 23, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Johns Cem.

Location Ellicott City, Md.

18. Funeral director E. Arthur Sims

Address Ellicott City, Md.

19. 2/27-48 VE. Harry  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 19 48 at 7:05 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19

Immediate cause of death

DURATION

Suicide  
Hanging, strangulation

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of Feb 25, 48

Where did injury occur? Catonsville, Baltimore, Md.  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) hospital

Means of injury Hanging from bed Injured at work? no

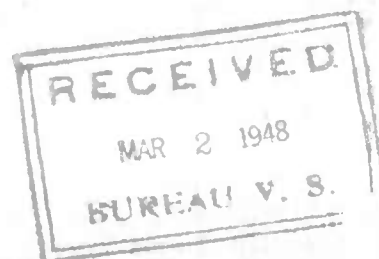
23. SIGNATURE Geo. M. Kieffer Evans  
 Address 1010 Leek on M. D. or other 2-25-48

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01428

Reg. Dist. No.

27

## 1. PLACE OF DEATH:

County BaltimoreCity or town Cockeysville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Cockeysville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Cora Offutt

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow

B.(b) Name of husband or wife Noah E. Offutt7. Birth date of deceased (mo., day, yr.) about 1865

B.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years About 83 ? Months ? Days ? If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation None11. Industry or business \*\*\*\*12. Name Johnson13. Birthplace Maryland14. Maiden name Frances Merryman15. Birthplace Maryland16. Informant J. Fred OffuttAddress Cockeysville, Md.17. Burial Druid Ridge(Burial, cremation, or removal, Which?) 2/11/48

Date thereof (month) (day) (year)

Cemetery or crematory Pikesville, Md.Location H W Mears and Son18. Funeral director 805 N. Calvert St., Baltimore,

Address

19. 2/9/48 19. 2/9/48

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9, 1948 19. 1948 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 25, 1948 to 2/9, 1948and that I last saw him alive on 2/9, 1948Immediate cause of death UremiaPresumably (Perinatal)Due to Hypertension + arteriosclerosiscardiac disease

Due to \_\_\_\_\_

Other conditions epilepsy

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. H. Townsend

M. D. or other \_\_\_\_\_

Address 14 E. Egan StDate signed 2/10/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

930 01429  
Reg. Dist. No. 37

### 1. PLACE OF DEATH:

County Baltimore  
City or town Texas  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 yr. 9 mo. 26 da  
Hospital, institution, or street address where death occurred:  
Baltimore County Home  
How long in hospital or institution? 4 yr. 9 mo. 26 da.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Texas  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Marion Olive

### 3. (b) Social Security Number

✓

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mary Claypool Olive

7. Birth date of deceased (mo., day, yr.) 8/8/62 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 85 Months 6 Days 20 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace State Texas U.S.A.  
(Town, county, and state)

10. Usual occupation Race Track Foreman

11. Industry or business \_\_\_\_\_

12. Name James Olive

13. Birthplace not known

14. Maiden name Julia Bruesher

15. Birthplace not known

16. Informant James F. Beutler  
Address 2108 Thistlebloom Ave.

17. Burial Mar 1 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Baltimore County Home Care  
Location Texas Maryland

18. Funeral director London Brooks  
Address Sparks, Ind.

19. Feb 28 1948 W. J. Philcoat  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1948 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 1943 to 2/28 1948 and that I last saw him alive on 2/28 1948

Immediate cause of death myocarditis

Due to Arteriosclerosis

Due to Senility

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Walter C. Emor M.D.  
Address Cockeysville Md Date signed 2/28/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 5 1948

BUREAU V. S.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 01430

**1. PLACE OF DEATH:**  
 (a) Baltimore City, Maryland  
 (b) Street address 2900 Hillcrest Avenue  
 (c) Hospital or institution:  
 (d) Length of stay in hospital or inst. (yrs., mos., or days)  
 (e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State md. (b) County Balto Co.  
 (c) City or town Baltimore  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. 2900 Hillcrest Avenue  
 (If rural give location)  
 (e) Citizen of foreign country? (Yes or No)  
 If yes, name country

**3 (a) FULL NAME** HENRY PABST

**3 (b) If veteran, name war** NO **3 (c) Social Security Account** No. 213-01-0881

**4. Sex** M **5. Color or race** W **6 (a) Single, married, widowed, or divorced.** Married

**6 (b) Name of husband or wife** Margaret A. Pabst.  
**6 (c) If alive, give age** 57 years

**7. Birth date of deceased (mo., day, yr.)** May 23, 1880

**8. AGE:** Years 67 Months 9 Days 3 If less than one day  
 hr. min.

**9. Birthplace** Baltimore, Maryland  
 (Town, county, and state)

**10. Usual Occupation** Retired

**11. Industry or business** Columbia Specialty Co.

**12. Name** John Pabst

**13. Birthplace** Germany

**14. Maiden Name** Mary Koenigbauer

**15. Birthplace** Germany

**16 (a) Informant** Mrs. Margaret Pabst

**(b) Address** 2900 Hillcrest Avenue  
Burial 3/3/48

**17 (a)** (Burial, cremation, or removal) **(b) Date thereof** 3/3/48  
 (month) (day) (year)

**(c) Cemetery or crematory** Sacred Heart Cemetery  
**Location** Baltimore, Maryland

**18 (a) Funeral director** HENRY SANDER & SONS, INC.

**(b) Address** NORTH AVE. & BROADWAY

**19 (a)** MAR 2 - 1948 Wilmington, Delaware, Md.  
 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** February 29, 1948, at 8 AM M

**21. I certify that death occurred on the date above stated; that I attend-**  
 ed deceased from Jan. 5, 1948, to Feb. 29, 1948,  
 and that I last saw him alive on Feb. 28, 1948.

**Immediate cause of death**

arteriosclerotic heart  
Disease  
**Due to** coronary  
arteriosclerosis  
**Due to**

**Other Conditions** bronchial  
asthma

**Date of operation** (Include pregnancy within 8 months of death)

**Major findings of operation:**

**of autopsy:**

**22. If death was due to external causes, fill in the following:**

(a) Accident, suicide, or homicide  
 (b) Date of occurrence at M  
 (c) Where did injury occur? (City or town) (County) (State)  
 (d) Did injury occur about home, on farm, industrial place, in public place? While at work?  
 (Specify type of place)

**(e) Means of injury**

**23. Signature** George Sawyer  
**Address** 4808 Harford Rd. **Date signed** 3/1/48 M. D.

**DURATION**

3 yrs  
5 yrs  
2 yrs  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01431

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, institution, or street address where death occurred:

220 Detroit Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 220 Detroit Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Henry Walker Pace

## 3. (b) Social Security Number

216-09-6963

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Minnie E. Pace7. Birth date of deceased (mo., day, yr.) 7 August 18728.(c) If alive, give age 68 years

8. AGE: Years Months Days If less than one day

75615hrs. min.9. Birthplace Woodbridge, Va.

(Town, county, and state)

10. Usual occupation Steel Worker11. Industry or business Steel Plant12. Name William Pace13. Birthplace Virginia14. Maiden name Mary Ricks15. Birthplace Virginia16. Informant Wallace BrooksAddress 6820 Belclare Rd. Dundalk17. Burial Date thereof Feb. 15, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory OaklawnLocation Eastern Blvd.18. Funeral director Roland E. FisherAddress 2112 Dundalk Ave.19. Feb 23 - 1948 Darwin L. Furber

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Feb 19 48 at 7:40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 19 48 to 22 Feb 19 48and that I last saw him alive on 22 Feb 19 48

Immediate cause of death

Carcinoma of Stomach and head of pancreas

DURATION

2 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bernard W. Sollod

M. D. or other

Address 8 Liberty Parkway Date signed 22 Feb 48

RECEIVED

FEB 25 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George  
 City or town Upper Marlboro  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

George W. Parker

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) 1878 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 70 Months ? Days ? If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)

10. Usual occupation Laborer11. Industry or business ?12. Name ?13. Birthplace ?14. Maiden name ?15. Birthplace ?16. Informant Hospital recordsAddress Catonsville-28, Md.

17. Burial Date thereof Feb. 16-48  
 (Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory Leahy HillLocation Southland, Md.18. Funeral director W. H. ProsserAddress Upper Marlboro, Md.

19. 2-14- 19 48 V. E. Harry  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 19 48 at 6:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10 19 48 to February 13 19 48  
 and that I last saw him alive on February 13 19 48

Immediate cause of death Cancer of infan  
tion DURATION 2 days

Due to Arteriosclerosis @ v.  
disease

Due to Hypertensive  
C. V. disease

Other conditions Malnutrition

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Signature Isadore Tuerk, M.D.Address Catonsville-28, Md. M. D. or other \_\_\_\_\_Date signed 2-13-48



5-1-48

RECEIVED

FEB 17 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County Balto.City or town N. L. Lawson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

626 Regester Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Lawson  
(If outside city or town limits, write RURAL and give nearest town)Street No. 626 Regester Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

LOUISA PRELL

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife George J. Prell

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Oct. 17, 1867

8. AGE:

Years

Months

Days

If less than one day

80

3

25

hrs.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

John Feldpusch

13. Birthplace

Balto.

MOTHER

14. Maiden name

Catherine Middendorf

15. Birthplace

Balto.

16. Informant

Mr. J. A. Kane

Address

626 Regester Ave.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

2/14/48

(month) (day) (year)

Cemetery or crematory

Loudon Park Cem.

Location

Balto., Md.

18. Funeral director

WILLIAM J. TICKNER & SONS

Address

Balto., Md.

19.

(Date rec'd by registrar)

19

48

19

48

19

48

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48

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Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1948, at 1:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 2, 1948 to Feb 12, 1948and that I last saw him alive on Feb 11/48Immediate cause of death asthma

DURATION

Due to cardio renalDue to drop of

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Tickner M.D.

M. D. or other

Address 3126 Howard St. Date signed Feb 13/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01434

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County 3 Sparrowe Point Md.City or town Sparrowe Point Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Sparrowe Point  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1062 9 St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John R. Price

## 3. (b) Social Security Number

240-15-1167

## 4. Sex

M

## 5. Color or race

Bl.

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Florine Price

## 7. Birth date of deceased (mo., day, yr.)

7/24/1908

## 6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

39

hrs.

min.

## 9. Birthplace

Ga.

(Town, county, and state)

## 10. Usual occupation

Laborer

## 11. Industry or business

Baltimore Steel Co.

## MOTHER

## 12. Name

John Henry Price

## 13. Birthplace

Ga.

## 14. Maiden name

Birdie Howell

## 15. Birthplace

Ga.

## 16. Informant

Florine Price

## Address

Wide Water Val.

## 17. Removal

Removal

Date thereof

Feb 8, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Wickory N. C.

## Location

Mrs. Ross J. Elliott's Daught

## 18. Funeral director

1129 N. Caroline St

## Address

## 19. Date

2/7

19

48W. W. Hedrick  
J.C.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1948 at 9:10 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

CHRONIC HEART DISEASEC AORTIC & MITRALINSUFFICIENCY

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? Home

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. W. Hedrick

Dept. Med. EXAMINER - Baltimore Md. U. Co. 1129 N. Caroline St

Address

Date signed 2/11/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01435

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 213 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, MarylandHow long in hospital or institution? 213 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore (5)  
(If outside city or town limits, write RURAL and give nearest town)Street No. 906 Shuter Street

(If rural, give LOCATION)

2.(a) If veteran, name war WW-2

## 3. (a) FULL NAME

ROBERT L. PRICE

## 3. (b) Social Security Number

unemployed

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Single6.(b) Name of husband or wife Single7. Birth date of deceased (mo., day, yr.) 10-4-27

5.(c) If alive, give age years

8. AGE: Years Months Days If less than one day

2041

hrs. min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Bernard Price13. Birthplace Unknown14. Maiden name Lillian M.N. Unknown15. Birthplace Richmond, Virginia16. Informant Clinical Records, Vets. Adm. HospitalAddress Ft. Howard, Maryland17. Burial Date thereof Feb 8/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Isles National Cemetery

Location

18. Funeral director Mrs Robert A. Elliott & SonAddress 1129 N. Caroline St

2/6 x8 H.W. Redenil

19. (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 19. 48 at 12:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 7, 19. 47 to February 5, 19. 48and that I last saw him alive on February 5, 19. 48

Immediate cause of death

Tuberculosis, pulmonary, far adv.active

Due to

Due to

Other conditions Tuberculosis, intestinal,moderateTuberculosis, left hip, moderate

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE H.C. MANAUGHH.C. MANAUGH, M.D. Chief Professional ser.Address V.A.H. Ft. Howard, Md. Date signed 2-5-48

DURATION

9 Yrs.plusunknown1 yr. plus

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of street address, birthplace, father's name, cemetery and its location, MARYLAND STATE DEPARTMENT OF HEALTH and addition of husband's name shown on:

2411 N. Charles St., Baltimore

01436

FILM No. G 114 MAR 10, 1948

# CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:  
County..... Baltimore  
City or town..... Catonville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Opitz Home  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland County..... Montgomery  
City or town..... Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 16 West Underwood Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Laura Hoss Printup

## 3. (b) Social Security Number

\*\*\*\*\*

4. Sex..... FEMALE 5. Color or race..... WHITE 6.(a) Single, married, widowed, or divorced..... Widowed  
6.(b) Name of husband or wife..... Joseph J. Printup  
7. Birth date of deceased (mo., day, yr.)..... 28 th. Sept. 1857 6.(c) If alive, give age..... years  
8. AGE: Years..... 90 Months..... 4 Days..... 12 If less than one day..... min.

9. Birthplace..... Virginia Jonesboro, Tennessee  
(Town, county, and state)

10. Usual occupation..... Retired Gov't. Employee

11. Industry or business..... Matthew Hoss

FATHER 12. Name..... Joseph J. Printup

13. Birthplace..... Tenn.

MOTHER 14. Maiden name..... Pricilla Smith

15. Birthplace..... Tenn.

16. Informant..... W. Ruben Pumphrey

Address..... Bethesda Maryland

17. Burial Date thereof..... Feb. 13, /48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Woodsboro, Glenwood Cemetery

Location..... District of Columbia - Montgomery Co. Md.

18. Funeral director..... W. Ruben Pumphrey

Address..... Bethesda - Md.

19. Feb. 10 1948 W.E. Harvey  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... FEB. 9 th. 1948 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 17 1947 to Feb. 9 1948 and that I last saw him alive on Feb. 8 1948

Immediate cause of death..... Acute Pulmonary Congestion DURATION..... 5 d.

Due to..... Ch. Hypertension

..... Cardio-vascular disease 1051 (C)

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... William K. Zellerbach M.D. M. D. or other

Address..... Catonville 25, Md. Date signed..... 2-9-48

RECEIVED  
FEB 12 1948  
BUREAU



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

830

01680/38

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Frederick  
City or town NEAR BARTHOLOMEW  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Frederick  
City or town BARTHOLOMEW  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. RURAL - MONROVIA  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

CORA SAMATHA PRITCHARD

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Thomas Pritchard

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1876 6.(c) If alive, give age 73 years

8. AGE: Years 71 Months 2 Days 18 If less than 000 day  
.....hrs. ....min.

9. Birthplace West Virginia  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Charles Croston

13. Birthplace West Virginia

14. Maiden name Rachel Maule

15. Birthplace West Virginia

16. Informant Mr. Thomas Pritchard

Address Monrovia, Md.

17. Burial Date thereof 3-1-48  
(Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or crematory Croston &

Location near Mt. Airy, Fred. Co. Md.

18. Funeral director C.M. Bratz

Address Winfield, Md.

19. Feb 29 1948 Luday W. Falcone  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1948 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 25 1948 to Feb 28 1948 and that I last saw him alive on Feb 27 1948

Immediate cause of death Cerebral hemorrhage DURATION 3 days

Due to arterio sclerosis with hypertension 10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ernest P. Roof Md M. D. or other

Address New Market, Md Date signed Feb 29/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

CITY

DATE OF BIRTH

COUNTY

PLACE OF DEATH

STATE

MEDICAL HISTORY

PREVIOUS ILLNESSES

CAUSE OF DEATH

DATE OF EXAMINATION

SIGNATURE OF PHYSICIAN

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF PHYSICIAN

DATE OF DEATH

PLACE OF DEATH

STATE

CITY

COUNTY

DATE OF EXAMINATION

SIGNATURE OF PHYSICIAN

DATE OF SIGNATURE

PLACE OF SIGNATURE

RECEIVED

MAR 6 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

### 1. PLACE OF DEATH:

County Baltimore  
City or town Mount Wilson  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 0 yrs., 1 mo., 8 days  
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T. B. Sanatorium  
How long in hospital or institution? 0 yrs., 1 mo., 8 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County   
City or town Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1209 E. Lanvale Street  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (a) FULL NAME

Mr. Austin S. Rather

### 3. (b) Social Security Number

212-03-9429

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Mrs. Edith Rather  
7. Birth date of deceased (mo., day, yr.) June 14, 1908 6. (c) If alive, give age 40 years  
8. AGE: Years 39 Months 7 Days 23 It less than one day hrs. min.

9. Birthplace Harford Co., Maryland  
(Town, county, and state)  
10. Usual occupation Stockroom Clerk  
11. Industry or business  
12. Name George Rather  
13. Birthplace Maryland  
14. Maiden name Ella Porter  
15. Birthplace Maryland

16. Informant Austin S. Rather  
Address 1209 E. Lanvale St., Balto., Md.  
17. Burial Persusie Cemetery Date thereof Feb. 10, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Persusie Cemetery  
Location Perryman, Harford Co., Md.  
18. Funeral director George J. Ruth, Inc.  
Address 1735 Harford Ave., Balto., Md.

19. Feb. 6, 1948 Earl T. Webster  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 1948 3:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 29, 1947 to Feb. 6, 1948 and that I last saw him alive on February 6, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 3 yrs. 6 mos.

Due to Tubercle bacilli  
(He had Streptomycin treatments).  
Due to

Other conditions Tuberculous Meningitis About 4 mos.

(Include pregnancy within 8 months of death)

Major findings of operations Extra-pleural pneumonolysis with Lucite Plombage Date of 12/16/47

Autopsy results   
PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of   
Where did injury occur?  (City or town)  (County)  (State)  
Injured at home, farm, industry, public place (where?)   
Means of injury  Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D. or other   
Address Mount Wilson, Md. Date signed 2/6/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01438 44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Maryland  
 How long in hospital or institution? 20 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County .....  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 428 E. Lorraine Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW-I

## 3. (a) FULL NAME

WILLIAM J. RATTIGAN

## 3. (b) Social Security Number

217-03-1293

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Estelle Rattigan

7. Birth date of deceased (mo., day, yr.) 12-31-96 6.(c) If alive, give age 46 years

8. AGE: Years 51 Months 1 Days 4 It less than one day ..... hrs. .... min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Michael Rattigan13. Birthplace Ireland14. Maiden name Eleanor Fleming15. Birthplace Ireland

16. Informant Clinical Records, Vets. Adm. Hospital  
Ft. Howard, Maryland  
 Address

17. Burial Date thereof 2-9-1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore's National Cemetery

Location

18. Funeral director Wiedefeld & SonAddress 501 E. 22nd St

19. 2/6/48 19 A. W. Hedrick  
 (Date used by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 19 48 at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 16, 19 48 to February 5, 19 48

and that I last saw him alive on February 5, 19 48

Immediate cause of death  
Tuberculosis, pulmonary, bilateral 10 Yrs.  
far advanced, active. plus

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated Above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Manaugh

H.C. MANAUGH, M.D. Chief Professional ser.

Address V.A.H. Ft. Howard, Md. Date signed 2-5-48

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH: Baltimore  
 County.....  
 City or town..... Raspeburg, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... life  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland..... County..... Baltimore  
 City or town..... Raspeburg, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 4920 Hazelwood Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
AUGUST REINHARDT

3. (b) Social Security Number

4. Sex..... male  
 5. Color or race..... white  
 6. (a) Single, married, widowed, or divorced..... widower

6. (b) Name of husband or wife..... Lucy L. Reinhardt

7. Birth date of deceased (mo., day, yr.)..... July 2nd, 1878  
 6. (c) If alive, give age..... years

8. AGE: Years..... 69 Months..... 7 Days..... 1  
 It less than one day..... hrs. .... min.

9. Birthplace..... Baltimore County, Md.  
 (Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business..... County Highway

12. Name..... Andrew Reinhardt

13. Birthplace..... Germany

14. Maiden name..... Augusta Wolfrum

15. Birthplace..... Baltimore, Md.

16. Informant..... Mrs. George Berger

Address..... 5001 Hazelwood Ave.

17. burial Date thereof..... 2/6/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Parkwood

Location..... Baltimore, Md.

18. Funeral director..... Lassahn Funeral Home

Address..... 7401 Belair Road

19. Feb 3 19 48 Mrs. A. L. Reinhardt  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 3rd 19 48 at 12:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26 19 47 to Feb 3 19 48  
 and that I last saw him alive on Feb 2 19 48

Immediate cause of death..... Toxic absorption  
 DURATION..... 1 day

Due to..... Hypertension - right kidney  
crisis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Manner of injury..... Injured at work?

23. SIGNATURE..... Michael J. Dausch M.D.  
 M. D. or other

Address..... 1 W. Overlea Ave Date signed 2/3/48

MARGIN RESERVED FOR BINDING

(I)

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 12 1948

BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01440 30

1. PLACE OF DEATH:  
County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 20 yrs.  
Hospital, institution, or street address where death occurred:  
5702 Edmondson Ave.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Md. County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5702 Edmondson Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME  
Albert C. Reuschlein

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Bessie Wolfe Reuschlein

7. Birth date of deceased (mo., day, yr.) March 7, 1875. 6. (c) If alive, give age years

8. AGE: Years 72 Months 11 Days 14 If less than one day hrs. min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business B. & O. R. R.

12. Name George Reuschlein  
13. Birthplace Maryland

14. Maiden name Margaret Schneider  
15. Birthplace Pa.

16. Informant Mrs. Bessie Reuschlein, (wife)  
Address 5702 Edmondson Ave.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb. 24/48.  
(month) (day) (year)

Cemetery or crematory Woodlawn  
Location Woodlawn, Balto. Co. Md.

18. Funeral director Harry D. Witke  
Address 4101 Edmondson Ave.

19. 2/24/48 (Date rec'd by registrar) 19. E. W. Helms Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21/48. 19. at 11:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 19. 47 to Feb 21 19. 48  
and that I last saw him alive on February 20 19. 48

Immediate cause of death Acute Coronary occlusion DURATION Sudden

Due to arteriosclerotic Cardio-vascular Disease about 10 years

Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operation  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of Injury Injured at work?

23. SIGNATURE Leo J. Gaver M.D. M. D. or other  
Address 1 mallow Hill ave, Baltimore, Md Date signed 2/23/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

2180

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 years, 8 months, 30 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 12 years, 8 months, 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 102 South Carrollton Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Nellie Rivers

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife ?  
 7. Birth date of deceased (mo., day, yr.) 1884  
 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 64 Months ? Days ? If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
 (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business Home

12. Name ?  
 13. Birthplace ?  
 14. Maiden name ?  
 15. Birthplace ?

16. Informant Hospital records  
 Address Catonsville 28, Maryland

17. Burial Date thereof 5-10-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Spring Grove State Hospital  
 Location Catonsville 28, Md.

18. Funeral director Spring Grove State Hospital  
 Address Catonsville 28, Md.

19. May 10 48 V.E. Harry  
 (Date recd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 19 48 at 4:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 19 36, to February 11 19 48  
 and that I last saw h...er alive on February 11 19 48

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_  
Acute intestinal obstruction 24 hrs.

Due to Syphilis indef.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Manner of injury \_\_\_\_\_ injured at work?

23. SIGNATURE Isadore Tuerk, M.D.  
 M. D. or other \_\_\_\_\_

Address Catonsville-28, Md. Date signed 3-18-48



**RECEIVED**

MAY 11 1948

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01441-238

## 1. PLACE OF DEATH:

County BaltimoreCity or town Towson 4, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since August 5, 1946Hospital, institution, or street address where death occurred:  
Eudowood Sanatorium, Towson 4, Md.How long in hospital or institution? Since August 5, 1946

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Lutherville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2 Garden Rd  
(If rural, give LOCATION)2.(a) If veteran, name war no

## 3. (a) FULL NAME

EDWARD Lee Robinson

## 3. (b) Social Security Number

216-03-03244. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced single6. (b) Name of husband or wife none7. Birth date of deceased (mo., day, yr.) August 23, 1912 6. (c) If alive, give age — years8. AGE: Years 35 Months 5 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Binghamton, N.Y.  
(Town, county, and state)10. Usual occupation Salesman11. Industry or business American Tea Company12. Name Lee Robinson13. Birthplace Montrose, PA.14. Maiden name Naura Hicken15. Birthplace Buffalo, New York16. Informant Personal History- Hospital RecordsAddress Eudowood Sanatorium, Towson 4, Md.17. Burial Date thereof Feb. 7, 1948  
(Burial, cremation, or removal) Which? (month) (day) (year)Cemetery or crematory Meadowridge MemorialLocation Washington Blvd., near Ellridge18. Funeral director John Burris' SonsAddress Towson, Md.19. 2/c 88 D. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 4, 1948 at 6:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5, 1946 to February 4, 1948and that I last saw him alive on February 4, 1948

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Pulmonary tuberculosis Since 1942

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. H. Bridges M. D. or other \_\_\_\_\_Address Towson 4, Md. Date signed 2-4-48

MARGIN RESERVED FOR BINDING

VS-A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Towson  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

419 Jefferson Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Baltimore

City or town..... Towson  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 419 Jefferson Ave.  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Fannie Rose

## 3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... Colored 6.(a) Single, married, widowed, or divorced..... Widow

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... Aug. 18, 1879 6.(c) If alive, give age..... years

8. AGE: Years..... 68 Months..... 6 Days..... 29 If less than one day..... hrs. .... min.

9. Birthplace..... New Kent Co., Va.  
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

FATHER 12. Name..... Patterson  
 13. Birthplace..... Va.

MOTHER 14. Maiden name..... Frances ?  
 15. Birthplace.....

16. Informant..... Mrs. Edith Smith  
 Address..... 402 Railroad Ave

17. Burial Date thereof..... 2-8-48  
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)  
 Cemetery or crematory..... Plesant Rest Cem.  
 Location..... Towson, Balto. Co., Md.

18. Funeral director..... Mrs. Frances A. Hemsley  
 Address..... 578 W. Biddle St.

19. 2/7 19 48 G. W. Friedrich  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 5 19 48 at 3:20 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 19 48 to Feb 5 19 48 and that I last saw him alive on Feb 5 19 48

Immediate cause of death.....

Cardiac Renal Disease

DURATION

Due to..... 1 yr.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... Miss B. Johnson M. D. or other

Address..... 2329 Green St. Date signed..... Feb 5 19 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

190

01443

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

## 1. PLACE OF DEATH:

County BaltimoreCity or town Quarritsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Quarritsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Quarritsville - Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Albert - Sadosky

## 3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Single

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1948 at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h..... alive on ..... 19.....

Immediate cause of death.....

DURATION

Due to ExposureDue to New elements

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geoffrey M. D. or otherAddress 1010 Reids Date signed 2-11-48

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug. 27 - 1893

6. (c) If alive, give age ..... years

8. AGE: Years 54 Months 6 Days 12 If less than one day ..... hrs. .... min.9. Birthplace Balto. Md.  
(Town, county, and state)10. Usual occupation Labourer11. Industry or business James & Sons Quarry12. Name August Sadosky13. Birthplace Germany14. Maiden name Juliana Schaffer15. Birthplace Germany16. Informant William E. SadoskyAddress Quarritsville - Md.17. Burial, cremation, or removal. Which? Burial Date thereof 11 Feb 48  
(month) (day) (year)Cemetery or crematory Lorraine ParkLocation Woodlawn - Md.18. Funeral director St. B. Whipple & SonAddress Baltimore, Md.19. 2-11-48 19..... A. W. [Signature] Registrar  
(Date rec'd by registrar)

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01444

Reg. Dist. No. *KX*

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Approximately 8-1/2 Hrs.  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Maryland  
How long in hospital or institution? Approximately 8-1/2 Hrs.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County   
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 217 President Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war Retired (Navy)

### 3. (a) FULL NAME

CLAUDE L. SCESE

### 3. (b) Social Security Number

unknown

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) 11-6-95 6.(c) If alive, give age  years

8. AGE: Years 52 Months 3 Days 4 It less than one day  hrs.  min.

9. Birthplace Michigan  
(Town, county, and state)

10. Usual occupation Cook & Baker

11. Industry or business

12. Name James Scese

13. Birthplace Michigan

14. Maiden name Emma Waddell

15. Birthplace Michigan

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Ft. Howard, Maryland

17. Burial Date thereof 2/13/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Baltimore National

Location Frederick Road

19. Funeral director Howard H. Blight Jr.

Address 4914 Belair Road

2. 12 19 48 DW Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 19 48 at 4:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 9, 19 48 to February 10, 19 48

and that I last saw him alive on February 10, 19 48

Immediate cause of death Pulmonary edema DURATION Sudden

Due to Right sided cardiac failure Unknown

Due to Pulmonary emphysema and pulmonary tuberculosis Unknown

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results Substantiated Above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur?  (City or town)  (County)  (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

23. SIGNATURE Imbernie M.D.

Address Baltimore, Md.

2/10/48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01445

Reg. Dist. No. 44

### 1. PLACE OF DEATH:

County *Balt* *Cedar Beach*  
City or town *Essex* *Zone 21*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* County *Balt*  
City or town *Cedar Beach #21*  
(If outside city or town limits, write RURAL and give nearest town)

Street No. *Essex*  
(If rural, give LOCATION)

2(a) If veteran, name war

### 3. (a) FULL NAME

*Edward John Schirmer*

### 3. (b) Social Security Number

*219-14-0713*

4. Sex *M.* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *Married*

### 6. (b) Name of husband or wife

*Nellie*

### 7. Birth date of deceased (mo., day, yr.)

*Aug 13 - 1880*

### 8. AGE:

Years *67* Months *67* Days *67* If less than one day hrs. min.

### 9. Birthplace

*Balto Md*  
(Town, county, and state)

### 10. Usual occupation

*Fireman*

### 11. Industry or business

FATHER

### 12. Name

*August Schirmer*

### 13. Birthplace

*Germany*

MOTHER

### 14. Maiden name

*Mary Dens*

### 15. Birthplace

*Germany*

### 16. Informant

*Nellie Schirmer*

### Address

*Cedar Beach Balto 21*

### 17.

(Burial, cremation, or removal) Which?

### Date thereof

*Buried 2-17-48*  
(month) (day) (year)

### Cemetery or crematory

*Oak Lawn*

### Location

*Balto Co.*

### 18. Funeral director

*H. Brueckner*

### Address

*1407 Eastern Ave Rd*

### 19.

(Date rec'd by registrar)

*2/16*

*19*

*48 R.W. Hedrick*  
*gm* Registrar

### MEDICAL CERTIFICATION

### 20. DATE OF DEATH

*February 13, 1948, at 10 P.M.*

### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Dec 48* to *Feb 13, 1948*

and that I last saw him alive on *13 February 1948*

### Immediate cause of death

*Respiratory Failure*

### DURATION

*2 days*

### Due to

*Heart Disease*

*10 yrs.*

### Due to

*Valvular Disease*

*10 yrs.*

### Other conditions

*of heart etiology*

(Include pregnancy within 3 months of death)

### Major findings of operations

Date of op.

### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

### Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

### 23. SIGNATURE

*Maxwell H. Mund*

M. D. or other

Address *417 1/2 Eastern Ave* Date signed *14 Feb 48*

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town NR Dundas - ny  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town NR Dundas - ny  
 (If outside city or town limits, write RURAL and give nearest town)Street No. 501 S 48th Street  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Jacob Schmidtmann

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

widower

## 6. (b) Name of husband or wife

Ella Mae

## 7. Birth date of deceased (mo., day, yr.)

July 18 - 1881

## 6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

66616

hrs.

min.

## 9. Birthplace

Balto MD

(Town, county, and state)

## 10. Usual occupation

laborer

## 11. Industry or business

FATHER

## 12. Name

Michael Schmidtmann

## 13. Birthplace

Germany

MOTHER

## 14. Maiden name

Augusta Thraswell

## 15. Birthplace

Germany

## 16. Informant

J. Michael Schmidtmann

## Address

501 S. 48th St.

## 17.

Burial  
 (Burial, cremation, or removal. Which?)

## Date thereof

2/7/48  
 (month) (day) (year)

## Cemetery or crematory

mt. Carmel

## Location

4th Donnell St.

## 18. Funeral director

John J. Connelly

## Address

418 Eastern Ave. Essex 21

## 19.

2/5/48  
 (Date rec'd by registrar)

19

John J. Connelly  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 1948 at 7:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... fo. 19...

and that I last saw h... alive on 19...

Immediately cause of death

Strangulation from hanging

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 2/4/48Where did injury occur? NR Dundas BALTO MD  
 (City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury hanging by from collar Injured at work?

23. SIGNATURE

Dr. J. J. Connelly MD  
 Address Dundas - Baltimore Date signed 2/5/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

01447

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County BaltimoreCity or town Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

319 Allegheny Avenue

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Towson  
(If outside city or town limits, write RURAL and give nearest town)Street No. 309 Allegheny Avenue  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Amelia Dorothea Schuler

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Frank Schuler

## 7. Birth date of

deceased (mo., day, yr.)

Jan. 5, 1863

6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Year

Month

Days

If less than one day

85110-

hrs.

-

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business At Home12. Name John Will13. Birthplace Germany14. Maiden name Sofia Garner15. Birthplace Germany16. Informant Frank SchulerAddress Towson, Md.17. Burial Date thereof Feb. 18, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Prospect Hill CemeteryLocation Towson, Md.18. Funeral director John Bunn's SonsAddress Towson, Md.19. Feb. 18 19 48  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1948 at 11:00 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 14 19 48 to Feb 15 19 48  
and that I last saw him alive on Feb 15 19 48

Immediate cause of death

DURATION

Myocardial decompensationDue to arterio-sclerosisDue to hypertension met.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Christine M. D.  
Address Towson, Md. Date signed 2/18/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

47d

re 01448

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

County BaltimoreCity or town Easttown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Int Pleasant Avenue  
How long in hospital or institution? 2 months & 25 days

## 3. (a) FULL NAME

Louis Skiller

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Esther Skiller

7. Birth date of deceased (mo., day, yr.)

February 15, 18806. (c) If alive, give age 56 years

8. AGE:

Years 67Months 11Days 20

If less than one day

hrs. min.

9. Birthplace

Russia  
(Town, county, and state)

10. Usual occupation

Upholsterer

11. Industry or business

Ironing Skiller

12. Name

13. Birthplace

Russia

14. Maiden name

15. Birthplace

Russia

16. Informant

Esther Skiller

Address

2145 Eagle St, Baltimore Ind

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

2-6-48  
(month) (day) (year)

Cemetery or crematory

Hebrew Young Men

Location

Windsor Mill Road

18. Funeral director

James Lewis Inc

Address

200 Easton Place19. 2/5/48

(Date rec'd by Registrar)

19

A. W. Hedrick

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town

Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2145 Eagle Street

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

February 5

19

48 at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 6

19

47

to

Feb 5

19

48and that I last saw him alive on Feb 5

19

48

Immediate cause of death

Myocardial Failure

DURATION

Due to

Empyema7 months

Due to

Pneumonia1 month

Pathological exam. of left lung at Sinai Hosp. Lab. shows Bronchiectasis with chronic

Other conditions interstitial pneumonitis and adenocarcinoma(4-15-48) Jams

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. P. Pugh M.D.

M. D. or other

Address

Easttown Ind

Date signed

2/5/48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01449

## 1. PLACE OF DEATH:

County..... *Glen Arm*City or town..... *Baltimore*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County..... *Glen Arm*City or town..... *Baltimore*  
(If outside city or town limits, write RURAL and give nearest town)Street No..... *Manor Road Long Green*  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife..... *Catherine L.*

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

*Jan. 19-1870*

8. AGE:

Years

Months

Days

If less than one day

*78**0**25*

hrs.

min.

9. Birthplace.....

*Harford Co. Md.*  
(Town, county, and state)

10. Usual occupation.....

*Farmer*

11. Industry or business

FATHER

12. Name.....

*Francis Smith*

13. Birthplace.....

*Md.*

MOTHER

14. Maiden name.....

*Alice R. Bussey*

15. Birthplace.....

*Md.*

16. Informant.....

*Mrs. Catherine Smith*

Address.....

*Manor Road, Long Green*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

*2/17/48*  
(month) (day) (year)

Cemetery or crematory.....

*St. John's Cem.*

Location.....

*Long Green Md.*

18. Funeral director.....

*Robert J. Kuck*

Address.....

*5305 Harford Rd.*

19. 2/17

(Date rec'd by registrar)

19

X8

A. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

*Feb-13<sup>th</sup> 1948* at *5 P.* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*August 12, 1947* to *Feb. 13, 1948*and that I last saw him alive on *Feb. 13, 1948*

Immediate cause of death

*Acute dilatation of heart*

Due to.....

*Rheumatic Carditis with Chronic*

Due to.....

*Endocarditis & Mitral Stenosis*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Address.....

*Clifford F. Hudson Md.*  
*York, Md.*

M. D. or other

Date signed *2/16/48*

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01450

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1206 West North Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John Smith

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) May 12, 1862  
 8. AGE: Years 85 Months 8 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore County, Maryland  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business Labor  
 12. Name ?  
 13. Birthplace ?  
 14. Maiden name ?  
 15. Birthplace ?

16. Informant Hospital records  
 Address Catonsville-28, Maryland  
 17. Burial Date thereof Feb. 9, 1948  
 (Burial, cremation, or removal) (month) (day) (year)  
 Cemetery or crematory Good Shepherd  
 Location Rogers Ave. Ellisth City, Md.  
 18. Funeral director E. A. S. S. S.  
 Address Ellisth City, Md.  
 19. Feb. 9 19 48 V. E. Harvey  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 19 48 at 8:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 21 19 48, to February 5 19 48  
 and that I last saw him alive on February 5 19 48

Immediate cause of death Arteriosclerotic heart disease DURATION years

Due to Generalized arteriosclerosis " "

Due to Malnutrition indefinite

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other 2-5-48Address Catonsville-28, Md. Date signed \_\_\_\_\_





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01451

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County..... Baltimore .. 19. 1948  
 City or town..... Sparks Point ..  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 6 years ..  
 Hospital, institution, or street address where death occurred:  
2910 Delmar Ave.  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....  
 City or town..... Box # 1 ..  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... None ..

## 3. (a) FULL NAME

Wylie Ebbert Smith

## 3. (b) Social Security Number

None

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Ella May Smith

## 7. Birth date of deceased (mo., day, yr.)

Jan. 10. 1878

## 6. (c) If alive, give age..... years

58

## 8. AGE:

Years

Months

Days

If less than one day

7015

..... hrs. .... min.

## 9. Birthplace

Shippensburg, Pa.

(Town, county, and state)

## 10. Usual occupation

Farming

## 11. Industry or business

own farm

## FATHER

## 12. Name

Joseph H. Smith

## 13. Birthplace

Pa.

## MOTHER

## 14. Maiden name

Sarah Kamm

## 15. Birthplace

Pa.

## 16. Informant

Ella Smith

## Address

address as in # 1

## 17. is

(Burial, cremation, or removal, Which?)

## Date thereof

Feb 16 1948

## Cemetery or crematory

ST. THOMAS

## Location

CHAMBERSBURG, PENNA.

## 18. Funeral director

William Cook, Inc.

## Address

1217 ST. PAUL ST.

## 19. (Date rec'd by registrar)

Feb 15 1948

## 20. (Date rec'd by registrar)

John G. Givally

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 15 .. 19. 48 .. at 1 A. .. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb.19toFeb. 141948

and that I last saw him alive on

Feb.141948

Immediate cause of death

Cerebral Thrombosis

DURATION

sudden

Due to

Hypertension4 years

Due to

Cardiovascular disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Louis N. Gallin

M. D. or other

Address

6908 North Point Rd.

Date signed

2/15/48



RECEIVED  
FEB 21 1948  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01452

30

Reg. Dist. No.

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville-28, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 17 yrs. 6 mos. 14 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 17 yrs. 6 mos. 14 days

## 3. (a) FULL NAME

STAAS, Agatha

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

GEORGE STAAS

7. Birth date of deceased (mo., day, yr.)

February 5, 1872

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

7619

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

DomesticMOTHER  
FATHER

12. Name

David N. Null

13. Birthplace

Maryland

14. Maiden name

Annie Wimer

15. Birthplace

Maryland

16. Informant

Hospital Records

Address

Catonsville-28, Maryland.

17.

BURIAL

Date thereof

Feb. 28, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

SPRING GROVE

Location

CATONSVILLE, MD

18. Funeral director

Harry H. Wight

Address

4101 Edmondson Ave

19.

2/28

19

48G.W. Hedrich

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty BaltimoreCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 720 N. Belnord Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 19 48 at 1:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 10 19 30, to February 24 19 48and that I last saw him or her on February 24 19 48Immediate cause of death Chronic myoCardiac insufficiencyDue to Coronary sclerosisDue to Arteriosclerotic heart dis.Generalized art selOther conditions Hypertensive CR

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk, M. D.

M. D. or other

Address Catonsville-28, Maryland Date signed 2-27-48

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

01453

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Balto  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Daughters of Eucharist Hosp.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County .....  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1802 Aiken St.  
(If rural, give LOCATION)  
2. (a) If veteran, name war .....

### 3. (a) FULL NAME

Bertha Stemler

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
6. (b) Name of husband or wife .....  
6. (c) If alive, give age ..... years  
7. Birth date of deceased (mo., day, yr.) July 23, 1875  
8. AGE: Year 72 Months 6 Days 13 If less than one day ..... hrs. .... min.

9. Birthplace Harrisburg, Pa.  
(Town, county, and state)

10. Usual occupation None

11. Industry or business .....

FATHER 12. Name John Stemler  
13. Birthplace Barania

MOTHER 14. Maiden name Theresa Mareck  
15. Birthplace Austria

16. Informant Mr. Bernard Smith  
Address 1802 Aiken St

17. Burial Date thereof 2/13/48  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Holy Redeemer  
Location Belden Rd

18. Funeral director John F. Henry Inc  
Address 114 Bright St

19. 2/7 19 48 A.W. Hedrich  
(Date rec'd by registrar) (year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 5<sup>th</sup> 19 48 at 8<sup>00</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 19 47 to Feb 5 19 48  
and that I last saw him alive on Feb 27 19 48

Immediate cause of death ..... DURATION

Acute cardiac failure with  
Due to .....

Due to Cardiovascular disease?

Other conditions senility ?  
(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. ....

Autopsy results .....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Georg M. Kieffer M. D. or other  
Address 1010 Leeds Ave Date signed 2-6-48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The completed page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

## 1. PLACE OF DEATH:

County... Baltimore  
 City or town... Fullerton, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Baltimore  
 City or town... Fullerton, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 7307 Linden Ave.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

ARTHUR L. STEVENS

## 3. (b) Social Security Number

217-07-5139

4. Sex male 5. Color or race negro 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mamie A. Stevens  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Oct. 5th, 1883  
 8. AGE: Years 64 Months 4 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace St. Mary's County, Md.  
 (Town, county, and state)  
 10. Usual occupation Janitor  
 11. Industry or business \_\_\_\_\_

FATHER 12. Name John L. Stevens  
 13. Birthplace St. Mary's County, Md.  
 MOTHER 14. Maiden name Holt  
 15. Birthplace St. Mary's County, Md.

16. Informant Mrs. A.L. Stevens  
 Address 7307 Linden Ave.

17. burial Date thereof 3/1/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Putty Hill  
Putty Hill, Md.  
 Location \_\_\_\_\_

18. Funeral director Lassahn Funeral Home  
 Address 7401 Belair Road

19. Feb. 27 19 48 Dr. R. L. Pendergast  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb. 26th 19 48 at 12:40p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 19 48 to Feb 25 19 48  
 and that I last saw him alive on 2-25 19 48

Immediate cause of death Cerebral Hemorrhage DURATION 2 days

Due to Arteriosclerosis many years

Due to \_\_\_\_\_

Other conditions Chronic Nephritis many years

(Include pregnancy within 3 months of death)

Major findings at operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Max R. English M. D. or other \_\_\_\_\_

Address 5713 Belair Rd. Date signed 2-27-48

RECEIVED

MAR 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The content age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01455

Reg. Dist. No. 41

## 1. PLACE OF DEATH

County Balto.City or town Dundalk 22  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

60 Norris Lane  
How long in hospital or institution? 6 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

William Elmer Sullivan

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Marie

## 7. Birth date of deceased (mo., day, yr.)

May 9/1899

## 8. AGE:

Years 50 Months 9 Days 9 If less than one day..... hrs. .... min.

## 9. Birthplace

Baltimore Co. Md.  
(Town, county, and state)

## 10. Usual occupation

Ice wagon

## 11. Industry or business

Own business

## MOTHER

12. Name Daniel Sullivan13. Birthplace Md.14. Maiden name Annie Cochran15. Birthplace Md.16. Informant Mr. Marie Sullivan (Imp)Address 60 Norris Lane, Dundalk, Md.17. Burial Date thereof 2-21-48  
(Burial, cremation, or removal? Which?) (month) (day) (year)Cemetery or crematory Sacred Heart Cem.Location German Hill Rd.18. Funeral director Lilly & Zeiler Inc.Address 403 S. Wolfe St.19. Feb 20 19 48 R W Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 19 48 at 10<sup>40</sup> P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death

Coronary accident

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, pub'c place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE

Wmearns M.D.  
Duty Medical Examiner  
Address Balto. Dundalk



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

01456

48

## 1. PLACE OF DEATH:

County... Baltimore - 19 -  
 City or town... Sparrows Point  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 weeks  
 Hospital, institution, or street address where death occurred:  
3104 Greenhill Ave.  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md. County... Balto - 19  
 City or town... Sparrows Point  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 7213 North Point Rd  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

EDNA BERNICE TALLEY.

## 3. (b) Social Security Number

none

## 4. Sex

Female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married.

## 8. (b) Name of husband or wife

Winifrey Talley.

## 7. Birth date of

deceased (mo., day, yr.)

Aug. 26. 1907.

6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

40514.

hrs.

min.

## 9. Birthplace

Baltimore County md.

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

own home

## FATHER

## 12. Name

Edwara Robertson

## 13. Birthplace

Stromaco Co. Md.

## MOTHER

## 14. Maiden name

Annice Jones

## 15. Birthplace

Baltimore - md.

## 18. Informant

Grace Walter

## Address

3109 Riverside Rd - Balto 19

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb 14 1948

Cemetery or crematory

Cedar Hill Cem

Location

Rural

## 18. Funeral director

Ulrich Funeral Home

Address

2008 Orleans St

## 19.

(Date rec'd by registrar)

19

A. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Feb. 9. 1948. 12 50 A. M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1945 to Feb. 9. 1948.and that I last saw him alive on Feb. 9 - 1948.

## Immediate cause of death

Adeno carcinoma  
cervix uteri

## DURATION

27 6 mo.

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

## Where did injury occur?

(City or town)

(County)

(State)

## Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

Louis N. Tollin M.D.6908 North Point Rd

M. D. or other

Address Balto - 19. md.Date signed 2/9/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01457

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Towson  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

Convent Nursing HomeHow long in hospital or institution? 2 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County BaltimoreCity or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)Street No. ....  
 (If rural, give LOCATION)

2. (a) If veteran, name war .....

## 3. (a) FULL NAME

William Tappan

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

WidowedB. (b) Name of husband or wife Sarah E.

## 7. Birth date of deceased (mo., day, yr.)

Jan 20, 1863

6. (c) If alive, give age ..... years

## 8. AGE:

Years 85

Months

Days

If less than one day

..... hrs. .... min.

9. Birthplace Steubenville, Ohio  
 (Town, county, and state)

## 10. Usual occupation

Retired

## 11. Industry or business

Professor (School)

## MOTHER FATHER

## 12. Name

Benjamin Tappan

## 13. Birthplace

Steubenville, Ohio

## 14. Maiden name

Nancy Louther

## 15. Birthplace

Unknown

## 16. Informant

Dr. Benjamin Tappan

## Address

6904 Bellona Ave.

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

2-28-48  
 (month) (day) (year)

## Cemetery or crematory

Union Cemetery

## Location

Steubenville, Ohio

## 18. Funeral director

Loring Dyers

## Address

5005 Park Avenue

## 19. 2/27/48

(Date rec'd by registrar)

19

A. W. Hedrick  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 19 48 at 4:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 43, to Feb 26 19 48 and that I last saw him alive on Feb 24 19 48

## Immediate cause of death

Cerebral thrombosis

## DURATION

2-3 days

## Due to

Arterio-sclerosis

## Gradual

✓

## Due to

Myocarditis

## Sudden

✓

## Other conditions

Myocarditis

(Include pregnancy within 3 months of death)

## Major findings of operations

..... Date of op. ....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

## 23. SIGNATURE

W. H. Hoody  
1403 Park Ave

M. D. or other

Address ..... Date signed 2-26-48

PLEASE WRITE PLAINLY, UNFADING INK. Supply every item of information equally. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

2181

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs. 3 mos. 17 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 4 yrs. 3 mos. 17 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Prince George'sCity or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Shady Grove Tourist Camp

(If rural, give LOCATION)

2.(a) If veteran, name war. ☒

## 3. (a) FULL NAME

George P. Taylor

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

December, 1870

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years 77Months 2

Days

If less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace

Elbert County, Georgia

(Town, county, and state)

10. Usual occupation

Odd Jobs

11. Industry or business

Farm

FATHER

12. Name F. M. Taylor13. Birthplace Georgia

MOTHER

14. Maiden name Mary Elizabeth Ayres15. Birthplace South Carolina

16. Informant

Hospital Records

Address

Catonsville 28, Md.

17.

Burial

Date thereof

5-10-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Spring Grove State Hospital

Location

Catonsville 28, Md.

18. Funeral director

Spring Grove State Hospital

Address

Catonsville 28, Md.

19.

May 10 1948

(Date rec'd by registrar)

V.E. Harry

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 19 48 12:05 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 819 43to February 25 19 48and that I last saw him alive on February 25 19 48

Immediate cause of death

Cachexia, undiagnosed

DURATION

1 monthDue to Osteomyelitis of the left heel1 monthDue to Chronic glomerular nephritisindef.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

23. SIGNATURE

Isadore Turk, M.D.

M. D. or other

Address Catonsville 28, Md.Date signed 2-25-48

RECEIVED

MAY 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

01458

## 1. PLACE OF DEATH:

County BaltimoreCity or town 7. Chesapeake  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 mo. 16 days

Hospital, institution, or street address where death occurred:

Baltimore County HomeHow long in hospital or institution? 2 mo. 16 days

## 3. (a) FULL NAME

James Taylor

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Back River  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4  
(If rural, give LOCATION)2(a) If veteran, name war ✓

## 3. (b) Social Security Number

4. Sex male5. Color or race col6. (a) Single, married, widowed, or divorced single8. (b) Name of husband or wife Francis Jones Taylor7. Birth date of deceased (mo., day, yr.) 11/15/768. AGE: Years 71 Months 3 Days 13 less than one day hrs. min.9. Birthplace Back River Balto. Co. Md.  
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Robert Taylor13. Birthplace Virginia14. Maiden name Elizabeth Blake15. Birthplace ?16. Informant Robert DennisAddress Box 139 Route 16Essex 21 Maryland17. Buried Date thereof 3-1-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. StephensLocation Essex Maryland18. Funeral director Mrs Robert Elliott St. DaughtonAddress 1129 North Caroline St. Balto. Md.19. 2/27 19 48 Wm J. Chilcoat  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 19 48 at 7:15 A-M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 11 19 47 to 2/27 19 48and that I last saw him alive on 2/26 19 48Immediate cause of death Carcinoma -  
(Gastric & Hepatic)

DURATION

Due to

Due to

Other conditions Hemorrhage - Gastric

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

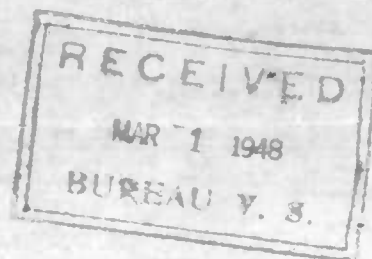
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William C. Enos M. D. or otherAddress Cockeysville Md. Date signed 2/27/48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01459

### 1. PLACE OF DEATH:

County Balto

City or town Essex  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Box 24 Sue Ave.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto

City or town Essex  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Box 24 Sue Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Certie Virginia Teestermann

### 3. (b) Social Security Number

4. Sex 7 5. Color or race W. 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Richard Teestermann

7. Birth date of deceased (mo., day, yr.) Nov 23 - 1919 6.(c) If alive, give age 28 years

8. AGE: Years 28 Months 2 Days 23 It less than one day .....hrs. ....min.

9. Birthplace Kentucky  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at home

12. Name John F. Fritz

13. Birthplace Kentucky

14. Maiden name Hannahs Tempie

15. Birthplace Kentucky

16. Informant Mrs. Richard Teestermann

Address Box 24 Sue Ave.

17. Burial Date thereof 2-18-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory moreland Park

Location Taylor Ave.

18. Funeral director John B. Connolly

Address 405 Eastern Ave.

19. 2/17/48 19. John B. Connolly  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 1948 at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN 31 1948 to FEB 15 1948 and that I last saw him alive on FEB. 9 1948

Immediate cause of death Pulmonary Edema DURATION 1 week

Due to Generalized metas. 1 yr

Due to Carcinoma 2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John B. Connolly M. D. or other

Address 405 Eastern Ave. Date signed 2/17/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 17 1948

BUREAU V. 5.

Evidence for change  
of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

01460

FILM No. G 114 MAR 11 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:  
County Baltimore  
City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 22 years  
Hospital, institution, or street address where death occurred:  
103 Linden Terrace  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 103 Linden Terrace  
(If rural, give LOCATION)  
2.(a) If veteran, name war None

3. (a) FULL NAME

JOHN ALBERT TOLSON

3. (b) Social Security Number

214-18-2877

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Alice Plunkett Tolson  
7. Birth date of deceased (mo., day, yr.) February 27, 1864  
8. AGE: Years 84 Months 11 Days 2 If less than one day — hrs. — min.

9. Birthplace Slainville, Ohio  
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business H. T. Campbell, Sons, Co.

12. Name John A. Tolson

13. Birthplace Unknown

14. Maiden name Elizabeth Taylor

15. Birthplace Unknown

16. Informant Mrs. Alice P. Tolson

Address 103 Linden Terrace, Towson, Md.

17. Burial Date thereof Feb 4, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Morland Memorial Park

Location Parkville, Maryland

18. Funeral director John Bunnie, Sons

Address Towson, Maryland

19. Feb 4 19 48 John A. Tolson Registrar  
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 19 48 at 4:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 Jan. 19 48 and that I last saw him alive on 1 Feb 19 48

Immediate cause of death Coronary Occlusion DURATION 1 Day

Due to Arteriosclerosis DURATION 1 Year

Due to Cardiovascular disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

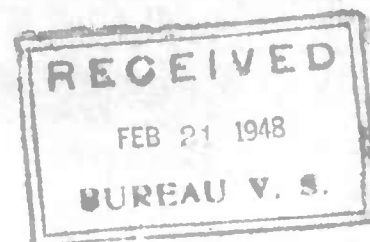
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. J. Reig M.D. M. D. or other

Address 6201 York Rd Date signed 3 Feb 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Kingsville, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 31 years  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore  
 City or town..... Kingsville, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Sunshine Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

EDWARD J. TRAUTMAN

## 3. (b) Social Security Number

218-18-0996

4. Sex..... male  
 5. Color or race..... white  
 6.(a) Single, married, widowed, or divorced..... married  
 6.(b) Name of husband or wife..... Elizabeth W. Trautman  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... Feb. 27th, 1882  
 8. AGE: Years..... 65 Months..... 11 Days..... 18 If less than one day..... hrs. .... min.

9. Birthplace..... Russia  
 (Town, county, and state)  
 10. Usual occupation..... Machinist

11. Industry or business..... Unknown  
 12. Name..... Unknown  
 13. Birthplace..... Unknown  
 14. Maiden name..... Unknown  
 15. Birthplace..... Unknown

16. Informant..... Mrs. Edward W. Trautman  
 Address..... Sunshine Ave., Kingsville, Md.

17. (Burial, cremation, or removal. Which?)..... burial Date thereof..... 2/18/48 (month) (day) (year)  
 Cemetery or crematory..... St. Michaels Lutheran  
 Location..... Fullerton, Md.

18. Funeral director..... Laseach Funeral Home  
 Address..... 7401 Belair Road

19. 2/16 48 A.W. Hedrick  
 (Date recd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 15th, 1948 at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10, 1947 to Feb 15, 48 and that I last saw him alive on Feb 14, 1948

Immediate cause of death..... Carcinoma of Lung  
 DURATION..... 7 mos.

Due to.....  
 Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. Signature..... Clifford F. Hudson M.D.  
 M. D. or other..... Fork Md.  
 Address..... Date signed..... 2/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Baltimore Co.  
CERTIFICATE OF DEATH

01462

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County 2309 Ruth ave Sparrow point

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No 2309 Ruth ave Sparrow point  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Willie Tucker

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

Col

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Agnes Tucker

## 6. (c) If alive, give age years

## 7. Birth date of

deceased (mo., day, yr.)

## 8. AGE:

50

Years

Months

11

Days

8

If less than one day

hrs.

min.

## 9. Birthplace

N.C. (Town, county, and state)

## 10. Usual occupation

Laborer

## 11. Industry or business

Virgil Tucker

## 12. Name

Virgil Tucker

## 13. Birthplace

N.C.

## 14. Maiden name

Easter S. Clark

## 15. Birthplace

N.C.

Mrs. Agnes X Tucker

Address 2309 Ruth ave Sparrow point

17. Shipped Date thereof 2-25-48  
(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory St. Paul Cemetery

Location St. Paul N.C. via Fayetteville N.C.

18. Funeral director Rayner Sanders

Address 1412 E. Preston Street

19. 2/28/48 H. D. Hedrick

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23-48 19 at 7 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-10-48 19 to 2-23-48 19

and that I last saw him alive on 2-23-48 19

Immediate cause of death Metastatic carcinoma

## DURATION

19x

Due to Stomach carcinoma

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William J. Johnson

M. D. or other

Address 4227 N. N. Street

Date signed 2-23-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Altamont Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Mary M. Knorr

## 7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age

years

## 8. AGE:

Years

Months

Days

If less than one day

80226

hrs.

min.

## 9. Birthplace

Ontario, Canada  
(Town, county, and state)

## 10. Usual occupation

Civil Engineer

## 11. Industry or business

Self

## 12. Name

William Tyrrell

## 13. Birthplace

London, England

## 14. Maiden name

Elizabeth Burr

## 15. Birthplace

Canada

## 16. Informant

Mary M. Tyrrell

## Address

Altamont Ave Catonsville, MD

## 17. (Burial, cremation, or removal) Which?

Burial

## Cemetery or crematory

London Park

## Location

Baltimore, MD

## 18. Funeral director

William G. G. G.

## Address

1217 H. Bond St19. Feb 6

(Date rec'd by registrar)

19 48a. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 19 48 at MD

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 19 47, to 4 February 19 48and that I last saw him alive on 4 February 19 48

## Immediate cause of death

Arteriosclerotic hypertensive cardiovascular disease

## DURATION

5-10 yrs.

## Due to

## Due to

## Other conditions

Diabetes mellitus, mild  
Chronic cystitis  
(Include pregnancy within 3 months of death)2 yrs.4 months

## Major findings of operations

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

## 23. SIGNATURE

John A. Hedrick

M. D. or other

Address 20 E. Preston St - Balt. 2 Date signed 6 Feb 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

## 1. PLACE OF DEATH:

County... Baltimore  
 City or town... Towson East linked opposite Fallible Rd & Gate Rd  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? unknown  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Unknown

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Newborn

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

## 8. AGE:

Years

Months

Days

If less than one day

Newborn, full term

hrs.

min.

## 9. Birthplace

(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## MOTHER FATHER

## 12. Name

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19.

(Date rec'd by registrar)

19 48

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

## State

## County

## City or town

(If outside city or town limits, write RURAL and give nearest town)

## Street No.

(If rural, give LOCATION)

## 2. (a) If veteran, name war

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Unknown Probably Feb. 48

19... at ... M

## 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19... to 19...

and that I last saw him

## Immediate cause of death

Newborn - cause unknown - full term probably dead 6-8 weeks. Umbilical cord not tied

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

## Where did injury occur?

(City or town)

(County)

(State)

## Injured at home, farm, industry, pub'c place (where?)

## Means of injury

## Injured at work?

## 23. SIGNATURE

Bollin C. Hudson MD D.M.E.

M. D. or other

## Address

Towson Md.Date signed 2/27/48

RECEIVED

APR 5 1948

BUREAU V. S.

# CERTIFICATE OF DEATH

Reg. Diat. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
County <u>Baltimore</u>				State <u>Maryland</u> County <u>Baltimore</u>			
City or town <u>Towson</u> (If outside city or town limits, write RURAL and give nearest town)				City or town <u>Towson</u> (If outside city or town limits, write RURAL and give nearest town)			
How long in above place of death? <u>1 year</u>				Street No. <u>515 Allegheny Avenue</u> (If rural, give LOCATION)			
Hospital, institution, or street address where death occurred: <u>515 Allegheny Avenue</u>				2.(a) If veteran, name war <u>1</u>			
How long in hospital or institution?							
3. (a) FULL NAME <u>Frances Lavina Warfel</u>				3. (b) Social Security Number			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Widow</u>		MEDICAL CERTIFICATION	
6. (b) Name of husband <u>Danlap Warfel</u>		6. (c) If alive, give age _____ years		20. DATE OF DEATH <u>February 11<sup>th</sup></u> 19 <u>48</u> , at <u>5 A.</u>		21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Jan 6<sup>th</sup></u> 19 <u>48</u> , to <u>Feb 11<sup>th</sup></u> 19 <u>48</u> , and that I last saw her alive on <u>Feb 10<sup>th</sup></u> 19 <u>48</u> .	
7. Birth date of deceased (mo., day, yr.) <u>October 17, 1863</u>		8. AGE: Years <u>84</u> Months <u>3</u> Days <u>24</u> If less than one day _____ hrs. _____ min.		Immediate cause of death <u>Cerebral Thrombosis</u>		DURATION <u>Sudden</u>	
9. Birthplace <u>Union County, Penna.</u> (Town, county, and state)		10. Usual occupation <u>Housewife</u>		Due to <u>Cerebral Artery Sclerosis</u>			
11. Industry or business <u>At Home</u>		12. Name <u>John Miller</u>		Due to <u>Myocardial Degeneration</u>			
13. Birthplace <u>Penna.</u>		14. Maiden name <u>Barbara Rich!</u>		Other conditions _____			
15. Birthplace <u>Penna.</u>		16. Informant <u>Miss Mildred Bayne</u>		(Include pregnancy within 3 months of death)			
Address <u>Towson, Md.</u>		17. <u>Burial Removal</u> Date thereof <u>Feb.</u> (month) (day) (year) <u>✓</u>		Major findings of operations _____		Date of op. _____	
Cemetery or crematory <u>Francis A. Gay Funeral Home</u>		Location <u>Norfolk, Virginia</u>		Autopsy results _____		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
18. Funeral director <u>John Burns' Sons</u>		Address <u>Towson, Maryland</u>		22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____		Where did injury occur? _____ (City or town) (County) (State)	
19. <u>Feb. 12 - 48</u> (Date rec'd by registrar)		Registrar <u>William H. Bond</u>		Injured at home, farm, industry, public place (where?) _____		Means of injury _____ Injured at work? _____	
23. SIGNATURE <u>Caecil A. H. Hoo</u>		Address <u>Towson, Md.</u>		Date signed <u>2/24/48</u>			

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 21 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

01465

53

## 1. PLACE OF DEATH:

County BaltimoreCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2641 Purnell Drive

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2641 Purnell Drive  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Elizabeth R. Watson

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow6.(b) Name of husband or wife Late Frank R. Watson

6.(c) if alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1882.

8. AGE:

Years

65

Months

6

Days

18

If less than one day

hrs.

min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

12. Name James Ringgold13. Birthplace Md.14. Maiden name Lena Gunther15. Birthplace Md.16. Informant Charles WatsonAddress 2641 Purnell Drive17. Burial Date thereof Feb. 14/48.  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory WoodlawnLocation Woodlawn, Md.18. Funeral director Harry H. WightAddress 4101 Edmondson Ave.19. Feb 14 1948  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 19 48 at 11:25 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 1 19 46 to February 12 19 48  
and that I last saw him alive on Feb 12 19 48

Immediate cause of death

Heart - nose - face

DURATION

1946

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE John H. Robert MD

M. D. or other

Address 4803 Park Heights Ave Date signed 2/13/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2

01466

### 1. PLACE OF DEATH:

County Baltimore  
City or town Towson 4, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Since December 24, 1947  
Hospital, institution, or street address where death occurred:  
Eudowood Sanatorium, Towson 4, Md.  
How long in hospital or institution? Since Dec 24, 1947

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Balt. City  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 310 N. Green  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Shelma Watson

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Sidney S. Watson

7. Birth date of deceased (mo., day, yr.) July 17, 1915 6. (c) If alive, give age 32 years

8. AGE: Years 32 Months 7 Days 9 It less than one day hrs. min.

9. Birthplace Roxborough, N.C.  
(Town, county, and state)

10. Usual occupation none given

11. Industry or business

12. Name Lynne Fugay

13. Birthplace N.C.

14. Maiden name Eliza Edwards

15. Birthplace N.C.

16. Informant Personal history - Hospital records

Address Eudowood Sanatorium, Towson 4, Md.

17. Burial Date thereof March 2-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oakwood Cem.

Location Richmond Va.

18. Funeral director John C. Miller Inc

Address 2436 E. Oliver St.

19. 2/28 19 48 A.W. Hedrich  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 19 48 at 9:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 24, 1947 to Feb 26, 1948 and that I last saw him alive on February 25, 1948

Immediate cause of death Pulmonary tuberculosis DURATION Since 1936

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.A. Bridges M. D. 2-26-48

Address Towson 4, Md. Date signed

46 MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01467

Reg. Dist. No. 43

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Raspeburg, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 24 years  
 Hospital, institution, or street address where death occurred:  
18 Elmont Ave.,  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Raspeburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 18 Elmont Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

WILLIAM C. WEAKLEY

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife Elizabeth A. Weakley

## 7. Birth date of

deceased (mo., day, yr.)

May 12th, 1869

## 6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

789

hrs.

min.

## 9. Birthplace

Pa.

(Town, county, and state)

## 10. Usual occupation

Engineer

## 11. Industry or business

James Distilling Co.

## FATHER

## 12. Name

Unknown

## 13. Birthplace

Unknown

## MOTHER

## 14. Maiden name

Unknown

## 15. Birthplace

Unknown

## 16. Informant

Mrs. William C. Weakley

## Address

18 Elmont Ave.17. burial

(Burial, cremation, or removal. Which?)

Date thereof

2/16/48

(month) (day) (year)

## Cemetery or crematory

Parkwood

## Location

Baltimore, Md.

## 18. Funeral director

## Address

Lassahn Funeral Home  
7401 Belair Road

## 19.

(Date rec'd by registrar)

19

Feb. 15 - 48 / Ms. G. L. Ruffin

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12th, 1948, at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 8, 1947, to Feb. 12, 1948  
and that I last saw him alive on Feb. 12, 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

20 hoursDue to Cardiovascular HypertensiveDisease5 yearsDue to Arteriosclerosis5 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Michael J. Dausch M.D.

M. D. or other

Address

1111 W. Overlea AveDate signed 2/13/48

**RECEIVED**

FEB 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. ~~Do not~~ correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
age and birth date shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 114 MAR 19 1948

## CERTIFICATE OF DEATH

Reg. Dist. No. *XX*

### 1. PLACE OF DEATH:

County... *Baltimore Co*

City or town... *St. Leonard*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *MD* County... *Balt*

City or town... *St. Leonard*  
(If outside city or town limits, write RURAL and give nearest town)

Street No. *Rural 10* Box *162*  
(If rural, give LOCATION)

2(a) If veteran, name war

### 3. (a) FULL NAME

*Mildred H Weeks*

### 3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widowed*

6. (b) Name of husband or wife... *Silas Weeks*

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) *Sept 8 - 11/8/47 1863*

8. AGE: Years *84* Months *10* Days *9* If less than one day  
hrs. min.

9. Birthplace... *New York*  
(Town, county, and state)

10. Usual occupation... *Dr. House*

11. Industry or business

12. Name... *Wm Heater*

13. Birthplace... *NY*

14. Maiden name... *Esther Deane*

15. Birthplace... *NY*

16. Informant... *Mrs Ester Morris*

Address... *514 Mt. Sparrow Pt*

17. *Burial* Date thereof... *Feb 19 1948*  
(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory... *Parson's Club*

Location... *City*

18. Funeral director... *Helbrick Funeral Home*

Address... *2008 Orleans St*

19. *18 48* A.W. Hedgcock  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH... *Feb 17 1948* at *12:45* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Jan 15 1948* to *Feb 17 1948*

and that I last saw her alive on *Feb 16 1948*

Immediate cause of death... *Cerebral Thrombosis* DURATION *48 hrs.*

Due to... *Arteriosclerosis-gen* ?

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... *Blindon M.D.* M. D. or other

Address... *520 D St* Date signed... *2-17-48*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01463

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County BaltimoreCity or town Hebbville  
(if outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:  
2200 Rolling Road

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Hebbville  
(if outside city or town limits, write RURAL and give nearest town)Street No. 2200 Rolling Road  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Hattie Ellen Weidemeyer

## 3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Female</u>	<u>White</u>	<u>Married</u>

6. (b) Name of husband or wife William A. Weidemeyer6. (c) If alive, give age 71 years7. Birth date of deceased (mo., day, yr.) June 21, 1882

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>7</u>	<u>6</u>	.....hrs. ....min.

9. Birthplace York County, Pa.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business At Home12. Name William H. Snyder13. Birthplace York County, Pa.14. Maiden name Miss Miller15. Birthplace York County, Pa.16. Informant Mr. William A. WeidemeyerAddress 2200 Rolling Road, Hebbville17. Burial Date thereat March 1, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Woodlawn CemeteryLocation Woodlawn, Md.18. Funeral director Wicks L. LumsdenAddress 4510 Liberty Heights Ave.19. Feb 29 1948 Dr. Kieffer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 1948, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on ..... 19.....

Immediate cause of death.....

DUE TO Coronary occlusion

DUE TO.....

DUE TO.....

DUE TO.....

DUE TO.....

DUE TO.....

DUE TO.....

DUE TO.....

DUE TO.....

DUE TO.....

DUE TO.....

DUE TO.....

DUE TO.....

DUE TO.....

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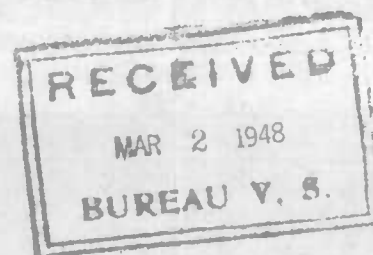
DUE TO.....

DUE TO.....

DUE TO.....

DUE TO.....

DUE TO.....





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01470  
30

1. PLACE OF DEATH: Shipley Ave.  
County... Calonsville, Md.  
City or town... (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For non-born infants give residence of mother)  
State... Md. County... Baltimore  
City or town... 100- Shipley Ave.  
Street No... (If rural, give LOCATION)  
2(a) If veteran, name war...

3. (a) FULL NAME

Louise Welling

3. (b) Social Security Number

4. Sex... Fem. 5. Color or race... Col. 6. (a) Single, married, widowed, or divorced... Married  
6. (b) Name of husband or wife... Arthur

7. Birth date of deceased (mo., day, yr.)... April 1, 1903. 8. (c) If alive, give age... years

8. AGE: 44 Years Months Days If less than one day  
md. hrs. min.

9. Birthplace... (Town, county, and state)

10. Usual occupation... Housewife.

11. Industry or business

12. Name... John Brooks

13. Birthplace... Clara Jackson

14. Maiden name... Wm. Brooks

15. Birthplace... 310- Winters Ave.

16. Informant... Burial 2-15-48

17. (Burial, cremation, or removal. Which?) Date thereof... (month) (day) (year)  
Cemetery or crematory... Blackston Cemetery

Location... Clarksburg, Md.

18. Funeral director... A. Hulstead

Address... 918- Almond Hill Ave.  
19. (Date rec'd by registrar) 1948 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 2-11-48 19... of 2.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-2-48 19... to 2-11-48 19... and that I last saw him alive on 2-11-48 19...

Immediate cause of death... Polar Pneumonia  
Due to... Rt. Saver

Other conditions... DURATION 9 days

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... B. J. Maloney

Address... Catonsville, Md. Date signed 2-12-48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01471

Reg. Dist. No. **XX**

## 1. PLACE OF DEATH:

County **Baltimore**City or town **Fort Howard**  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? **11 days**

Hospital, institution, or street address where death occurred:

**Vets. Adm. Hospital, Ft. Howard, Md.**How long in hospital or institution? **11 days**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** CountyCity or town **Baltimore**  
(If outside city or town limits, write RURAL and give nearest town)Street No. **628 Sarah Ann Street**

(If rural, give LOCATION)

2. (a) If veteran, name war **VV I**

## 3. (a) FULL NAME

**HENRY F. WHEATLEY**

## 3. (b) Social Security Number

4. Sex

**Male**

5. Color or race

**Colored**

6. (a) Single, married, widowed, or divorced

**Separated**6. (b) Name of husband or wife **Eleanor Wheatley**

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **6/15/93**

8. AGE: Years Months Days If less than one day

**54****8****14**

hrs. min.

9. Birthplace **Baltimore, Md.**  
(Town, county, and state)10. Usual occupation **Laborer**

## 11. Industry or business

12. Name **Henry F. Wheatley**13. Birthplace **Dorchester Co., Md.**14. Maiden name **Elizabeth Johnson**15. Birthplace **Baltimore, Md.**16. Informant **Clinical Records, Vets. Adm. Hosp.**Address **Fort Howard, Maryland**17. Burial **2/4/48**

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory **Baltimore National**Location **5501 Frederick Rd. Balto., Md.**18. Funeral director **James Hayes**Address **142 W. Hill Street, Baltimore, Md.**19. **3/2/48** 19. **A. W. Hedrick**

(Date recd by registrar) (Signature of Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH **February 29** 19 **48** at **1:30 AM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

**February 18** 19 **48** to **February 29** 19 **48**and that I last saw him alive on **February 29** 19 **48**

Immediate cause of death

**Pneumonia, right upper lobe**

DURATION

**unknown**Due to **Pneumococcus**

Due to

Other conditions **None**

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results **Substantiated above**

DIAGN: Please underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

Accident or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **H. C. MANAUGH****H. C. MANAUGH, M.D.** Chief Professional Ser.Address **VAH, Ft. Howard, Md.** Date signed **3/1/48**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01472 43

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Raspeburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? life  
 Hospital, institution, or street address where death occurred:  
7525 Belair Road  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.  
 City or town Raspeburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 7525 Belair Road  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

GEORGE W. WHITTLE

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife Johanna C. Whittle  
 6. (c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) Oct. 28th, 1874  
 8. AGE: Years 73 Months 3 Days 22 If less than one day  
 .....hrs. ....min.

9. Birthplace Balto. Co., Md.  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Thomas A. Whittle

13. Birthplace Balto. Co., Md.

14. Maiden name Susanne Russel

15. Birthplace Balto. Co., Md.

16. Informant Mrs. Anna Wild

Address 7525 Belair Road

17. burial Date thereof Feb. 21, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Moreland Memorial Park

Location Balto. Co., Md.

18. Funeral director Russell Funeral Home

Address 7401 Belair Road

19. Feb. 21 19 48 Mrs. A. I. Reifsnider  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 20th, 19 48 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
JAN. 1 19 45, to FEB. 19 19 48  
 and that I last saw him alive on FEB. 19 19 48

Immediate cause of death SENILITY DURATION 3 yrs +

Due to  
 Due to

Other conditions General arteriosclerosis 3 yrs +  
Benign Hypertrophy of Prostate gland "  
 (Include pregnancy within 3 months of death)

Major findings of operation  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE J. Whacker M.D.  
 Address 6331 Belair Rd Date signed 2/20/48

RECEIVED

FEB 26 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 01473 30

1. PLACE OF DEATH:  
 County Baltimore County  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 10. Holmehurst Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

George Wiskow

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Josephine Wiskow  
 7. Birth date of deceased (mo., day, yr.) 12-1-1896 6.(c) If alive, give age 51 years  
 8. AGE: Years 51 Months 2 Days 22 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore Maryland  
 (Town, county, and state)  
 10. Usual occupation Retired General Manager  
 11. Industry or business Charles Wiskow & Co.  
 12. Name Charles Wiskow  
 13. Birthplace Germany  
 14. Maiden name Katharina Block  
 15. Birthplace Germany

16. Informant Josephine S. Wiskow  
 Address 10. Holmehurst Ave.  
 17. Burial Date thereof 26 Feb 48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory London Park  
 Location Baltimore Md

18. Funeral director St B Wisbert & Son  
 Address 300 Centaur Place  
 19. 2-25-48 Myrdal  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 - 1948 at 12:25 AM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 7 - 1947 to Feb 23 - 1948  
 and that I last saw him alive on 2/23 1948

Immediate cause of death Vegetative Endocarditis and myocardial decompensation DUE TO  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Blood cultures positive with streptococcus and different organisms.  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Manner of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Daniel P. Aliga M. D. or other \_\_\_\_\_  
 Address 3347 Jorden St Date signed 2/24/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

01474

## 1. PLACE OF DEATH:

County BaltimoreCity or town Burial  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1220 - 48th St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltiCity or town Burial  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1220 - 48th St  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Harvey Wynn

## 3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Katherine H. Wynn

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age 27 years

8. AGE:

Years 68

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Irish Valley Pa  
(Town, county, and state)

10. Usual occupation

Pipe fitter

11. Industry or business

MOTHER FATHER

12. Name

Imbeck Wynn

13. Birthplace

Pa

14. Maiden name

Claressa Campbell

15. Birthplace

Pa

16. Informant

Mrs Katherine Wynn

Address

1220 - 48th St

17.

(Burial, cremation, or removal. Which?)

Date thereof

Burial Feb. 19th  
(month) (day) (year)

Cemetery or crematory

Oak Lawn Cem

Location

City

18. Funeral director

Ulrich Funeral Home

Address

2008 Orleans St

19.

(Date rec'd by registrar)

2/1848A.W. Haduch

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16th 1948 at 2-2 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h. alive on

19

Immediate cause of death

Coronary Occlusion

DURATION

7 min

Due to

Due to

Other conditions

Sickle Muth

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

MB Davis MD  
Sup. Med. Exam. (State) D. of Health  
2/18/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01475

Reg. Dist. No.

### 1. PLACE OF DEATH:

County.....Baltimore  
City or town.....Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....2 days  
Hospital, institution, or street address where death occurred:  
Veterans Administration Hospital  
How long in hospital or institution?.....2 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Wicomico  
City or town.....Willards  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....WWII

### 3. (a) FULL NAME

JAMES H. YOUNG, JR.

### 3. (b) Social Security Number

224-16-2572

4. Sex.....Male 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Married

6.(b) Name of husband or wife.....Mrs. Gracie Young  
6.(c) If alive, give age.....41 years

7. Birth date of deceased (mo., day, yr.).....March 22, 1904

8. AGE: Years.....43 Months.....10 Days.....22 If less than one day.....hrs. ....min.

9. Birthplace.....Accomac, Va.  
(Town, county, and state)

10. Usual occupation.....Unemployed

11. Industry or business.....

12. Name.....James H. Young

13. Birthplace.....Virginia

14. Maiden name.....Polly Nelson

15. Birthplace.....Virginia

16. Informant.....Clinical Records, Vet. Adm. Hosp.

Address.....Fort Howard, Maryland

17. Burial Date thereof.....2 / 13 / 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Edgehill Cemetery

Location.....Accomac, Va.

18. Funeral director.....Blight Funeral Home

Address.....1914 Belair Road, Baltimore, Md.

19. 2-13-48  
(Date rec'd by registrar) Registrar.....

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....February 13 19.....48 at.....3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....February 11 19.....48 to.....February 13 19.....48

and that I last saw him.....alive on.....February 13 19.....48

Immediate cause of death.....CORONARY ARTERIO-

SCIEROTIC CARDIAC DISEASE WITH

CARDIAC HYPERTROPHY & DILATATION,

WITH DECOMPENSATION; CLASS IV

DURATION.....18 mo 1

Due to.....

Other conditions.....Hepatomegaly, secondary to

above

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....None done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....C. E. Shaw

M. D. or other

Address.....VAH, Fort Howard, Md.

Date signed.....

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.